ATTACHMENT D:

SAMHSA REQUEST FOR APPLICATIONS FOR FY 2007:

"COOPERATIVE AGREEMENT FOR NETWORKING, CERTIFYING AND TRAINING SUICIDE PREVENTION HOTLINES"

RFA NO. SM-07-009 (2007)

Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines

(Initial Announcement)

Request for Applications (RFA) No. SM-07-009

Catalogue of Federal Domestic Assistance (CFDA) No.: 93.243

Key Dates:

Application Deadline	**Applications are due by May 2, 2007.**
Intergovernmental Review (E.O. 12372)	**Letters from State Single Point of Contact (SPOC) are due no later than 60 days after application deadline.**
Public Health System Impact Statement (PHSIS)/Single State Agency Coordination	**Applicants must send the PHSIS to appropriate State and local health agencies by application deadline. Comments from Single State Agency are due no later than 60 days after application deadline.**

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Executive Summary:

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2007 for a Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines. The purpose of this program is to manage, enhance, and strengthen the National Suicide Prevention Lifeline (NSPL), a system of toll-free telephone numbers that routes calls from anywhere in the United States to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources. The technology permits calls to be directed immediately to a suicide prevention worker who is geographically closest to the caller.

Funding Opportunity Title:	Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines
Funding Opportunity Number:	SM-07-009
Due Date for Applications:	May 2, 2007
Anticipated Total Available Funding:	$2.88 million
Estimated Number of Awards:	1
Estimated Award Amount:	Up to $2.88 million
Length of Project Period:	Up to 5 years
Eligible Applicants:	Domestic public and private nonprofit entities. [See Section III-1 of this RFA for complete eligibility information.]

I. FUNDING OPPORTUNITY DESCRIPTION

1. INTRODUCTION

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services is accepting applications for fiscal year (FY) 2007 for a Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines. The purpose of this program is to manage, enhance, and strengthen the National Suicide Prevention Lifeline (NSPL), a system of toll-free telephone numbers that routes calls from anywhere in the United States to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources. The technology permits calls to be directed immediately to a suicide prevention worker who is geographically closest to the caller.

The Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines program is one of SAMHSA's infrastructure programs.

SAMHSA's Infrastructure Grants support an array of activities to help the grantee build a solid foundation for delivering and sustaining effective mental health services. SAMHSA recognizes that each applicant will start from a unique point in developing infrastructure and will serve populations/communities with specific needs. The awardee may pursue diverse strategies and methods to achieve its infrastructure development and capacity expansion goals. The successful applicant will provide a coherent and detailed conceptual "roadmap" of the process by which it has assessed or intends to assess service system needs and plans/implements infrastructure development strategies that meet those needs. The plan put forward in the grant application must show the linkages among needs, the proposed infrastructure development strategy, and increased system capacity that will enhance and sustain effective programs and services.

The Cooperative Agreement for Networking, Certifying, and Training Suicide Prevention Hotlines is authorized under Section 520A of the Public Health Service Act, as amended. This announcement addresses Healthy People 2010 focus area 18 (Mental Health and Mental Disorders).

Background

It is estimated that there are more than 500 crisis centers in the United States, exclusive of military and employee assistance programs. Some centers focus on domestic violence or rape crises; others respond to all types of personal and family crises. The primary objective of crisis centers is to diffuse the immediate crisis, ensure the caller's safety, and assist the caller in taking the next immediate steps toward resolving the problem. Centers generally maintain databases of crisis, mental health, and social services to which callers can be referred, as needed.

In published surveys, 10 percent of telephone calls to crisis programs involve suicidal thoughts or behaviors. Telephone "hotline" crisis center services, especially those that train their staff in suicide prevention, represent one of many possible effective interventions for suicidality. A 2001 SAMHSA-funded evaluation of telephone crisis centers indicated that:

- Among crisis callers, distress decreases during and after calls.
- Crisis hotlines are reaching seriously suicidal callers; 12% of suicidal callers reported that the call saved their lives.
- Suicidality decreases during calls.

Suicide prevention hotlines are staffed with trained workers who establish and maintain contact with the individual while identifying and clarifying the problem, evaluating the risk for suicide, assessing the individual's strengths and resources, and mobilizing available resources including paramedic or police intervention and emergency psychiatric care, as needed.

Although suicide prevention hotlines have existed for more than 40 years, in many areas access to such services is either highly variable or non-existent. As is true for crisis hotlines in general, suicide prevention hotlines are diverse. Hotline services can be offered in combination with face-to-face client services or can exist as stand-alone, "hotline-only" programs. Such hotline-only centers can be hundreds or thousands of miles from the location of the caller. In addition to the stand-alone organizations, centers can be part of larger community-based organizations or components of organized health and mental health care delivery systems such as hospitals or community mental health centers.

Unless crisis centers are part of an organized health care delivery system, they may not be required to meet independent certification or licensing standards. State laws and regulations governing the use of terms such as "crisis center," "crisis line," or "hotline" either do not exist or vary widely. States generally do license or certify most mental health professionals, but while crisis centers tend to use professionals to conduct face-to-face suicide risk assessments and counseling, they frequently use trained lay volunteers to do telephone counseling and crisis intervention. Volunteers do not fall under State licensing or certification laws.

Most crisis centers strive to provide quality services and recognize the fact that workers responding to suicidal callers should be trained in the use of crisis intervention techniques. This has spawned the development of standards to guide the work of crisis centers. Additionally, many crisis centers voluntarily obtain and maintain certification from external, independent bodies to meet nationally recognized suicide prevention standards. This voluntary certification is virtually the only form of external, task-specific quality control that exists for many crisis centers.

The results of two recent SAMHSA-funded evaluations of crisis center effectiveness indicated that:

- Crisis line worker selection criteria should include empathy, respect, and the ability to establish good initial contact;
- Suicide risk assessments need to be conducted routinely on all NSPL crisis center calls to avoid missing potential suicidality; and
- Crisis worker training should include skill-building in the above areas.

2. EXPECTATIONS

The Networking, Certifying, and Training Suicide Prevention Hotlines cooperative agreement awardee must ensure that the following program goals are met:

- Manage, enhance, and strengthen the National Suicide Prevention Lifeline (NSPL), a system of toll-free suicide prevention telephone numbers that routes calls from anywhere in the United States to a network of certified local crisis centers that can link callers to local emergency, mental health, and social service resources;

- Manage a sustained outreach effort to new and existing hotlines that: (1) promotes effective communication; and (2) encourages additional qualified crisis centers to join the network, especially hotlines in underserved areas that serve populations at high risk for suicide;

- Increase the number of crisis hotlines that are: (1) certified in suicide prevention by a recognized body or agency; and (2) able to meet NSPL's minimum clinical standards in suicide risk assessment; and

- Collect, analyze, and report data regarding the technical efficiency and effectiveness of the telephone service that is provided to callers.

2.1 Allowable Activities

SAMHSA's Networking, Certifying, and Training Suicide Prevention Hotlines cooperative agreement funds must be used to carry out the following **11 required activities**.

- Establish and maintain a system or "network," through which telephone technology links crisis centers to toll-free suicide prevention lines. This network must automatically route calls from anywhere in the United States to the crisis center that is in the closest proximity to the caller and must have a demonstrated surge capacity (i.e., the ability to re-route calls when there is a sudden, large influx of calls; for example, immediately following a public service announcement).
- Establish and manage a system that maintains timely, ongoing communications with existing networked crisis centers.
- Manage and facilitate communication within and among the NSPL's National Steering Committee, Consumer/Recipients Subcommittee, and Certification and Training Subcommittee.
  [NOTE: The National Steering Committee, comprised primarily of crisis center directors, provides the NSPL grantee with expert guidance on the issues that affect the network; the Consumer/Recipient Subcommittee provides consumer/family/youth/recipient perspectives in reviewing standard network practices, marketing materials/promotional campaigns, and evaluations of network coverage and caller demographics; and the Certification and Training Subcommittee, comprised of professionals in the field, identifies and recommends essential, minimum standards for network member center credentialing and quality service.]

- Conduct outreach activities targeted to crisis centers that may potentially join the network, especially those centers in underserved areas and/or serving populations that are at high risk for suicidal behaviors. Particular attention should be paid to providing language-appropriate services and serving Tribal communities and survivors of suicide attempts.
- Increase the number of crisis hotlines certified in suicide prevention by a recognized body or agency.
- Provide technical assistance and training to the network to meet clinical standards for lethality assessment.
- Develop a computer simulation training module on suicide risk assessment and intervention for crisis center workers.
- Provide training and technical assistance to the Network and crisis center workers to improve cultural competence in engagement, suicide risk assessment, intervention, and linkage to appropriate services.
- Enhance the capacity of networked crisis centers to follow up with callers and to strengthen linkages within their local mental health systems.
- Accurately collect, analyze, and report data to SAMHSA including but not limited to call connectivity, call volume, and basic trends in calls received.
- Assist with responding to individuals who write to the President or Vice President of the United States threatening suicide.
- If the grantee is not the incumbent Lifeline provider, the grantee will be required to develop and implement a plan to address and ensure the coordination of an orderly transition of network services, activities, and materials both at the beginning and end of the grant period.

2.2 Data Collection and Performance Measurement

All SAMHSA grantees are required to collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results Act (GPRA).

The expected outcomes of this initiative are increased public access to certified crisis centers that can link callers at risk for suicidal behaviors to local emergency, mental health, and social service resources. The successful applicant will be required to collect and report data on the following items: number of calls received; State from which call was received; where call was routed; number of connected calls; number of dropped calls; number of callers who received busy signals; number of rings before a call is answered; average length of calls; and other items as directed by the GPO.

In addition, the successful applicant is required to establish a complaint procedure for addressing concerns raised by service recipients. The applicants must notify the GPO within 24 hours of receiving a complaint and the outcomes of any actions taken.

You must document your ability to collect and report the required data in "Section D: Performance Assessment and Data" of your application.

2.3 Performance Assessment

You must assess your project, addressing the performance measures described in Section I-2.2. The assessment should be designed to help you determine whether you are achieving the goals, objectives and outcomes you intend to achieve and whether adjustments need to be made to your project. You will be required to report on your progress achieved, barriers encountered, and efforts to overcome these barriers in a performance assessment report to be submitted at least annually.

In addition to assessing progress against the performance measures required for this program, your performance assessment must also consider process questions, such as the following:

Process Questions:

- How closely did implementation match the plan?
- What types of deviation from the plan occurred?
- What led to the deviations?
- What effect did the deviations have on the planned intervention and performance assessment?
- Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?

No more than 20% of the total grant award may be used for data collection, performance measurement, and performance assessment, e.g., activities required in Sections I-2.2 and 2.3.

2.4 Grantee Meetings

The NSPL Project Director must attend an initial meeting with the SAMHSA Government Project Officer (GPO) and other Federal staff involved with Federal suicide prevention efforts to discuss and clarify roles, responsibilities, project activities, and timelines. This meeting will take place at SAMHSA headquarters in Rockville, MD, and will be held shortly after the cooperative agreement begins. The NSPL Project Director will also meet at least bi-weekly with the GPO, primarily by telephone.

The Grantee must also participate in a NSPL crisis center conference that is currently in the planning stage. The conference will be held in fall 2007.

II. AWARD INFORMATION

Funding Mechanism:	Cooperative Agreement
Anticipated Total Available Funding:	$2.88 million
Estimated Number of Awards:	1

Estimated Award Amount: Up to $2.88 million

Length of Project Period: Up to 5 years

Proposed budgets cannot exceed $2.88 million in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, and timely submission of required data and reports.

Cooperative Agreement

The award is being made as a cooperative agreement because it requires substantial post-award Federal programmatic participation in the conduct of the project. Under this cooperative agreement, the roles and responsibilities of grantee and SAMHSA staff are as follows:

Role of Grantee

The role of the grantee is to comply with the terms of the award and all cooperative agreement rules and regulations, and satisfactorily perform activities to achieve the goals described below:

- Seek SAMHSA approval for key positions to be filled. Key positions include project director, networking/telephone director, certification director, evaluation director, database director;
- Seek SAMHSA approval of hotline networking system prior to implementation and accept SAMHSA proposed modifications;
- Consult with and accept guidance from SAMHSA staff on performance of activities to achieve goals of the cooperative agreement;
- Report data electronically on calls received to SAMHSA weekly;
- Respond to requests for information from SAMHSA; and
- Manage the multiple toll-free telephone numbers selected by SAMHSA through the end of the cooperative agreement period and relinquish control of the telephone numbers to SAMHSA or to another organization, if required.

Role of SAMHSA Staff

- Maintain overall responsibility for monitoring the implementation and progress of the suicide prevention hotline network system and certification program;
- Approve proposed key positions/personnel;

- Review proposed networking system and request modifications as necessary and appropriate consistent with SAMHSA priorities;
- Provide guidance and technical assistance on network design;
- Provide guidance on recruitment of new crisis centers in the network to ensure that at least one crisis center per State is participating;
- Approve data collection plans and institute policies regarding data collection;
- Provide technical assistance on sustainability and dissemination of the resource database to non-networked crisis centers; and
- Make recommendations regarding continued funding.

III. ELIGIBILITY INFORMATION

1. ELIGIBLE APPLICANTS

Eligible applicants are domestic public and private nonprofit entities. For example, State and local governments, federally recognized American Indian/Alaska Native tribes and tribal organizations, urban Indian organizations, public or private universities and colleges; and community- and faith-based organizations may apply. The statutory authority for this program prohibits grants to for-profit agencies.

2. COST SHARING

Cost sharing is not required in this program.

3. OTHER

You must comply with the following requirements, or your application will be screened out and will not be reviewed: use of the PHS 5161-1 application; application submission requirements in Section IV-3 of this document; and formatting requirements provided in Appendix A of this document.

IV. APPLICATION AND SUBMISSION INFORMATION

1. ADDRESS TO REQUEST APPLICATION PACKAGE

You may request a complete application kit from the SAMHSA Information Line at 1-877-SAMHSA7 [TDD: 1-800-487-4889].

You also may download the required documents from the SAMHSA Web site at www.samhsa.gov/grants/index.aspx

Additional materials available on this Web site include:

- a technical assistance manual for potential applicants;
- standard terms and conditions for SAMHSA grants;
- guidelines and policies that relate to SAMHSA grants (e.g., guidelines on cultural competence, consumer and family participation, and evaluation); and
- list of certifications and assurances referenced in item 21 of the SF 424 v2.

2. CONTENT AND FORM OF APPLICATION SUBMISSION

2.1 Application Kit

SAMHSA application kits include the following documents:

- PHS 5161-1 (revised July 2000) – Includes the face page, budget forms, assurances, certification, and checklist. You must use the PHS 5161-1. **Applications that are not submitted on the required application form will be screened out and will not be reviewed.**

- Request for Applications (RFA) – Provides specific information about the availability of funds along with instructions for completing the grant application. This document is the RFA. The RFA will be available on the SAMHSA Web site (www.samhsa.gov/grants/index.aspx) and a synopsis of the RFA is available on the Federal grants Web site (www.Grants.gov).

You must use all of the above documents in completing your application.

2.2 Required Application Components

Applications must include the required ten application components (Face Page, Abstract, Table of Contents, Budget Form, Project Narrative and Supporting Documentation, Appendices, Assurances, Certifications, Disclosure of Lobbying Activities, and Checklist).

- ❑ **Face Page** – Use Standard Form (SF) 424 v2, which is part of the PHS 5161-1. [Note: Applicants must provide a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. SAMHSA applicants are required to provide their DUNS number on the face page of the application. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the Dun and Bradstreet Web site at www.dunandbradstreet.com or call 1-866-705-5711. To expedite the process, let Dun and Bradstreet know that you are a public/private nonprofit organization getting ready to submit a Federal grant application.]

- ❑ **Abstract** – Your total abstract should not be longer than 35 lines. It should include the project name, target population, proposed catchment area, proposed strategies/methods, project goals and measurable objectives to manage, enhance, and strengthen the National Suicide Prevention Lifeline (NSPL). In the first five lines or less of your abstract, write a summary of your project that can be used, if your project is funded, in publications, reporting to Congress, or press releases.

- ❑ **Table of Contents** – Include page numbers for each of the major sections of your application and for each appendix.

- ❑ **Budget Form** – Use SF 424A, which is part of the 5161-1. Fill out Sections B, C, and E of the SF 424A. A sample budget and justification is included in Appendix **E** of this document.

- ❑ **Project Narrative and Supporting Documentation** – The Project Narrative describes your project. It consists of Sections A through D. Sections A-D together may not be longer than 25 pages. (Remember that if your Project Narrative starts on page 5 and ends on page 30, it is 26 pages long, not 25 pages.) More detailed instructions for completing each section of the Project Narrative are provided in "Section V—Application Review Information" of this document.

  The Supporting Documentation provides additional information necessary for the review of your application. This supporting documentation should be provided immediately following your Project Narrative in Sections E through H. There are no page limits for these sections, except for Section G, Biographical Sketches/Job Descriptions. Additional instructions for completing these sections are included in Section V under "Supporting Documentation."

- ❑ **Appendices 1 through 4** – Use only the appendices listed below. If your application includes any appendices not required in this document, they will be disregarded. Do not use more than a total of 30 pages for Appendices 1, 3 and 4 combined. There are no page limitations for Appendices 2. Do not use appendices to extend or replace any of the sections of the Project Narrative. Reviewers will not consider them if you do.

  - *Appendix 1*: Letters of Commitment/Coordination/Support
  - *Appendix 2*: Data Collection Instruments/Interview Protocols
  - *Appendix 3*: Sample Consent Forms
  - *Appendix 4*: Letter to the SSA (if applicable; see Section IV-4 of this document)

- ❑ **Assurances** – Non-Construction Programs. Use Standard Form 424B found in the PHS 5161-1.

- ❑ **Certifications** - You must read the list of certifications provided on the SAMHSA Web site or in the application kit before signing the face page of the application.

- ❑ **Disclosure of Lobbying Activities** – Use Standard Form LLL found in the PHS 5161-1. Federal law prohibits the use of appropriated funds for publicity or propaganda purposes, or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or State legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact

their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way.

- **Checklist** – Use the Checklist found in the PHS 5161-1. The Checklist ensures that you have obtained the proper signatures, assurances and certifications and is the last page of your application.

2.3 Application Formatting Requirements

Please refer to Appendix A, *Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications*, for SAMHSA's basic application formatting requirements. Applications that do not comply with these requirements will be screened out and will not be reviewed.

3. SUBMISSION DATES AND TIMES

Applications are due by close of business on **May 2, 2007**. **Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).**

Your application must be received by the application deadline, or you must have proof of its timely submission as specified below.

- **For packages submitted via DHL, Federal Express (FedEx), or United Parcel Service (UPS), proof of timely submission shall be the date on the tracking label affixed to the package by the carrier upon receipt by the carrier. That date must be at least 24 hours prior to the application deadline. The date affixed to the package by the applicant will not be sufficient evidence of timely submission.**

- For packages submitted via the United States Postal Service (USPS), proof of timely submission shall be a postmark not later than 1 week prior to the application deadline, and the following upon request by SAMHSA:
  - proof of mailing using USPS Form 3817 (Certificate of Mailing), or
  - a receipt from the Post Office containing the post office name, location, and date and time of mailing.

You will be notified by postal mail that your application has been received.

Applications not meeting the timely submission requirements above will not be considered for review. Please remember that mail sent to Federal facilities undergoes a security screening prior to delivery. Allow sufficient time for your package to be delivered.

If an application is mailed to a location or office (including room number) that is not designated for receipt of the application, and that results in the designated office not receiving your application in accordance with the requirements for timely submission, it will cause the application to be considered late and ineligible for review.

SAMHSA will not accept or consider any applications sent by facsimile.

SAMHSA is collaborating with www.Grants.gov to accept electronic submission of applications. Please refer to Appendix B for "Guidance for Electronic Submission of Applications."

4. INTERGOVERNMENTAL REVIEW (E.O. 12372) REQUIREMENTS

This cooperative agreement program is covered under Executive Order (EO) 12372, as implemented through Department of Health and Human Services (DHHS) regulation at 45 CFR Part 100. Under this Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs. Certain jurisdictions have elected to participate in the EO process and have established State Single Points of Contact (SPOCs). A current listing of SPOCs is included in the application kit and can be downloaded from the Office of Management and Budget (OMB) Web site at www.whitehouse.gov/omb/grants/spoc.html.

- Check the list to determine whether your State participates in this program. You **do not** need to do this if you are an American Indian/Alaska Native tribe or tribal organization.

- If your State participates, contact your SPOC as early as possible to alert him/her to the prospective application(s) and to receive any necessary instructions on the State's review process.

- For proposed projects serving more than one State, you are advised to contact the SPOC of each affiliated State.

- The SPOC should send any State review process recommendations to the following address within 60 days of the application deadline. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville MD **20857**. ATTN: SPOC – Funding Announcement No. **SM-07-009**. Change the zip code to **20850** if you are using another delivery service.

In addition, if you are a community-based, non-governmental service provider and you are not transmitting your application through the State, you must submit a Public Health System Impact Statement (PHSIS)[1] to the head(s) of appropriate State or local health agencies in the area(s) to be affected no later than the application deadline. The PHSIS is intended to keep State and local health officials informed of proposed health services grant applications submitted by

[1] approved by OMB under control no. 0920-0428; Public reporting burden for the Public Health System Reporting Requirement is estimated to average 10 minutes per response, including the time for copying the face page of SF 424 v2 and the abstract and preparing the letter for mailing. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0920-0428. Send comments regarding this burden to CDC Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428).

community-based, non-governmental organizations within their jurisdictions. If you are a State or local government or American Indian/Alaska Native tribe or tribal organization, you are not subject to these requirements.
The PHSIS consists of the following information:

- a copy of the face page of the application (SF 424 v2); and
- a summary of the project, no longer than one page in length, that provides: 1) a description of the population to be served, 2) a summary of the services to be provided, and 3) a description of the coordination planned with appropriate State or local health agencies.

For SAMHSA grants, the appropriate State agencies are the Single State Agencies (SSAs) for substance abuse and mental health. A listing of the SSAs can be found on SAMHSA's Web site at www.samhsa.gov. If the proposed project falls within the jurisdiction of more than one State, you should notify all representative SSAs.

If applicable, you must include a copy of a letter transmitting the PHSIS to the SSA in **Appendix 4, "Letter to the SSA."** The letter must notify the State that, if it wishes to comment on the proposal, its comments should be sent not later than 60 days after the application deadline to the following address. **For United States Postal Service:** Crystal Saunders, Director of Grant Review, Office of Program Services, Substance Abuse and Mental Health Services Administration, Room 3-1044, 1 Choke Cherry Road, Rockville MD **20857**. ATTN: SSA – Funding Announcement No. **SM-07-009**. Change the zip code to **20850** if you are using another delivery service.

In addition:

- Applicants may request that the SSA send them a copy of any State comments.

- The applicant must notify the SSA within 30 days of receipt of an award.

5. FUNDING LIMITATIONS/RESTRICTIONS

Cost principles describing allowable and unallowable expenditures for Federal grantees, including SAMHSA grantees, are provided in the following documents, which are available at http://www.hhs.gov/grantsnet (Grants Policies and Regulations):

- Institutions of Higher Education: OMB Circular A-21
- State and Local Governments and Federally Recognized Indian Tribal Governments: OMB Circular A-87
- Nonprofit Organizations: OMB Circular A-122
- Hospitals: 45 CFR Part 74, Appendix E

In addition, SAMHSA's Networking, Certifying, and Training Suicide Hotlines cooperative agreement recipients must comply with the following funding restrictions:

- Cooperative agreement funds must be used for purposes supported by the program.

- No more than 20% of the cooperative agreement award may be used for data collection and performance assessment expenses.

- Cooperative agreement funds may not be used to pay for the purchase or construction of any building or structure to house any part of the grant project. (Applicants may request up to $75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.)

SAMHSA will not accept a "research" indirect cost rate. The grantee must use the "other sponsored program rate" or the lowest rate available.

6. OTHER SUBMISSION REQUIREMENTS

You may submit your application in either electronic or paper format:

Submission of Electronic Applications

SAMHSA is collaborating with www.Grants.gov to accept electronic submission of applications. Electronic submission is voluntary. No review points will be added or deducted, regardless of whether you use the electronic or paper format.

To submit an application electronically, you must use the www.Grants.gov apply site. You will be able to download a copy of the application package from www.Grants.gov, complete it off-line, and then upload and submit the application via the Grants.gov site. E-mail submissions will not be accepted.

Please refer to Appendix B for detailed instructions on submitting your application electronically.

Submission of Paper Applications

You must submit an original application and 2 copies (including appendices). The original and copies must not be bound. Do not use staples, paper clips, or fasteners. Nothing should be attached, stapled, folded, or pasted.

Send applications to the address below:

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road

Rockville, MD **20857**

Change the zip code to **20850** if you are using another delivery service.

Do not send applications to other agency contacts, as this could delay receipt. Be sure to include **"Networking, Certifying, and Training Suicide Prevention Hotlines SM-07-009"** in item number 12 on the face page of any paper applications. If you require a phone number for delivery, you may use (240) 276-1199.

Hand carried applications will not be accepted. Applications may be shipped using only DHL, Federal Express (FedEx), United Parcel Service (UPS), or the United States Postal Service (USPS).

SAMHSA will not accept or consider any applications sent by facsimile.

V. APPLICATION REVIEW INFORMATION

1. EVALUATION CRITERIA

The Project Narrative describes what you intend to do with your project and includes the Evaluation Criteria in Sections A-D below. Your application will be reviewed and scored according to the quality of your response to the requirements in Sections A-D.

- In developing the Project Narrative section of your application, use these instructions which have been tailored to this program. **These are to be used instead of the "Program Narrative" instructions found in the PHS 5161-1**.

- The Project Narrative (Sections A-D) together may be no longer than 25 pages.

- You must use the four sections/headings listed below in developing your Project Narrative. Be sure to place the required information in the correct section, **or it will not be considered**. Your application will be scored according to how well you address the requirements for each section of the Project Narrative.

- Reviewers will be looking for evidence of cultural competence in each section of the Project Narrative, and will consider how well you address the cultural competence aspects of the evaluation criteria when scoring your application. SAMHSA's guidelines for cultural competence can be found on the SAMHSA Web site at www.samhsa.gov. Click on "Grants/Applying for a New SAMHSA Grant/Guidelines for Assessing Cultural Competence."

- The Supporting Documentation you provide in Sections E-H and Appendices 1-4 will be considered by reviewers in assessing your response, along with the material in the Project Narrative.

- The number of points after each heading is the maximum number of points a review committee may assign to that section of your Project Narrative. Bullet statements in each section do not have points assigned to them. They are provided to invite the attention of applicants and reviewers to important areas within the criterion.

Section A: Statement of Need (10 points)

- Describe the target population (see Glossary). Include demographics; issues of language, beliefs, norms and values; socioeconomic factors; historic use of hotline services; and the number of people that could be potentially served through the National Suicide Prevention Lifeline (NSPL).

- Document the need to enhance, strengthen, and increase the capacity of the NSPL. Documentation of need may come from local data or trend analyses, State data (e.g., from State Needs Assessments), and/or national data (e.g., from SAMHSA's National Survey on Drug Use and Health or from National Center for Health Statistics/Centers for Disease Control reports). For data sources that are not well known, provide sufficient information on how the data were collected so reviewers can assess the reliability and validity of the data.

- Describe the service gaps, barriers, and other problems related to ensuring that the NSPL reaches all States by including at least one crisis center in each State. Describe the resources in the target area that can help implement the needed infrastructure development and improve coordination and referral between the NSPL and other services, e.g., mental health, substance abuse, social services, etc.

Section B: Proposed Approach (35 points)

- Clearly state the purpose of the proposed project, with goals and objectives. Describe how achievement of goals will increase system capacity to support effective suicide prevention and mental health services.

- Thoroughly describe how you will carry out each of the **11 required activities** listed above in Section I-2.1. Describe how the required activities meet the goals and objectives of increasing service coverage of the NSPL.

- Describe any other organizations that will participate and their roles and responsibilities. Demonstrate their commitment to the project. Include letters of commitment/coordination/support from these community organizations in **Appendix 1** of your application.

- Describe how the proposed project will address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender in the target population.

- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them.

- Describe how your activities will improve suicide prevention and mental health services.

- Describe how program continuity will be maintained when there is a change in the operational environment (e.g., staff turnover, change in project leadership) to ensure stability over time.

Section C: Staff, Management, and Relevant Experience (30 points)

- Provide a realistic time line for the entire project period (chart or graph) showing key activities, milestones, and responsible staff. [Note: The time line should be part of the Project Narrative. It should not be placed in an appendix.]

- Discuss the capability and experience of the applicant organization and other participating organizations with similar projects (e.g., projects involving crisis centers and suicide prevention hotlines) and populations, including experience in providing culturally appropriate/competent services.

- Provide a list of staff who will participate in the project, showing the role of each and their level of effort and qualifications. Include the Project Director, networking/telephone director, certification director, evaluation director, and database director.

- Discuss how key staff have demonstrated experience in serving the target population and are familiar with the culture of the target population. If the target population is multilinguistic, indicate if the staffing pattern includes bilingual and bicultural individuals.

- Describe the resources available for the proposed project (e.g., facilities, equipment).

Section D: Performance Assessment and Data (25 points)

- State your intention to cooperate with an independent evaluator contracted by SAMHSA to evaluate the effectiveness of network services.

- Describe the process evaluation you will conduct. Include specific performance measures related to the goals and objectives identified for the project in Section B of your Project Narrative.

- Describe plans for data collection, management, analysis, interpretation and reporting. Describe the existing approach to the collection of data, along with any necessary modifications. Describe how you will collect and report data on call connectivity; call routing by State; daily call volume by time; call detail by crisis center; basic trends in calls received; use of the national suicide prevention telephone numbers (including variations by State and area code); speed of connectivity to the crisis center; and rate of

connectivity to the crisis center in closest proximity to the caller. Be sure to include data collection instruments/interview protocols (if any) in **Appendix 2.**

- Document your ability to collect and report on the required performance measures as specified in Section I-2.2 of this RFA, including data required by SAMHSA to meet GPRA requirements. Specify and justify any additional measures you plan to use for your grant project.

- Describe how data will be used to manage the project and assure continuous quality improvement.

- Describe your plan for conducting the performance assessment as specified in Section I-2.3 of this RFA and document your ability to conduct the assessment.

NOTE: Although the budget for the proposed project is not a review criterion, the Review Group will be asked to comment on the appropriateness of the budget after the merits of the application have been considered.

SUPPORTING DOCUMENTATION

Section E: Literature Citations. This section must contain complete citations, including titles and all authors, for any literature you cite in your application.

Section F: Budget Justification, Existing Resources, Other Support. You must provide a narrative justification of the items included in your proposed budget, as well as a description of existing resources and other support you expect to receive for the proposed project. Be sure to show that no more than 20% of the total grant award will be used for data collection and performance assessment. An illustration of a budget and narrative justification is included in Appendix E of this document.

Section G: Biographical Sketches and Job Descriptions.

- Include a biographical sketch for the Project Director and other key positions. Each sketch should be 2 pages or less. If the person has not been hired, include a position description and/or letter of commitment with a current biographical sketch from the individual.
- Include job descriptions for key personnel. Job descriptions should be no longer than 1 page each.
- Information on what should be included in biographical sketches and job descriptions can be found on page 22, Item 6, in the Program Narrative section of the PHS 5161-1 instruction page, available at www.hhs.gov/forms/PHS-5161-1.doc.

Section H: Confidentiality and Participant Protection Requirements: Applicants must describe procedures relating to Confidentiality, Participant Protection and the Protection of Human Subjects Regulations in Section H of the application, using the guidelines provided below. More detailed guidance for completing this section can be found in Appendix D of this RFA.

Confidentiality and Participant Protection:

Because of the confidential nature of the work in which many SAMHSA grantees are involved, it is important to have safeguards protecting individuals from risks associated with their participation in SAMHSA projects. All applicants must address the eight bullets below. If some are not applicable or relevant to the proposed project, simply state that they are not applicable and indicate why. In addition to addressing these eight bullets, read the section that follows entitled Protection of Human Subjects Regulations to determine if the regulations may apply to your project. If so, you are required to describe the process you will follow for obtaining Institutional Review Board (IRB) approval. While we encourage you to keep your responses brief, there are no page limits for this section and no points will be assigned by the Review Committee. Problems with confidentiality, participant protection, and the protection of human subjects identified during peer review of the application may result in the delay of funding.

- Identify foreseeable risks or adverse effects due to participation in the project and/or in the data collection (performance assessment) activities (including physical, medical, psychological, social, legal, and confidentiality) and provide your procedures for minimizing or protecting participants from these risks.

- Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

- Describe the target population and explain why you are including or excluding certain subgroups. Explain how and who will recruit and select participants.

- State whether participation in the project is voluntary or required. If you plan to provide incentives/compensate participants, specify the type (e.g., money, gifts, coupons), and the value of any such incentives. Provide justification that the use of incentives is appropriate, judicious, and conservative and that incentives do not provide an "undue inducement" which removes the voluntary nature of participation. Incentives should be the minimum amount necessary to meet the programmatic and performance assessment goals of the grant. Applicants should determine the minimum amount that is proven to be effective by consulting with existing local programs, reviewing the relevant literature. In no case may the value of an incentive exceed $20.

- Describe data collection procedures, including sources (e.g., participants, school records) and the data collecting setting (e.g., clinic, school). Provide copies of proposed data collection instruments and interview protocols in **Appendix 2**, "Data Collection Instruments/Interview Protocols." State whether specimens such as urine and/or blood will be obtained and the purpose for collecting. If applicable, describe how the specimens and process will be monitored to ensure the safety of participants.

- Explain how you will ensure privacy and confidentiality of participants' records, data collected, interviews, and group discussions. Describe where the data will be stored, safeguards (e.g., locked, coding systems, storing identifiers separate from data), and who will have access to the information.

- Describe the process for obtaining and documenting consent from adult participants and assent from minors along with consent from their parents or legal guardians. Provide copies of all consent forms in **Appendix 3** of your application, "Sample Consent Forms." If needed, give English translations.

- Discuss why the risks are reasonable compared to expected benefits from the project.

Protection of Human Subjects Regulations

SAMHSA expects the grantee funded under this announcement will not have to comply with the Protection of Human Subjects Regulations (45 CFR 46), which requires Institutional Review Board (IRB) approval. However, in some instances, the applicant's proposed performance assessment design may meet the regulation's criteria of research involving human subjects. Applicants whose projects must comply with the Human Subjects Regulations must, in addition to the bullets above, fully describe the process for obtaining IRB approval. While IRB approval is not required at the time of grant award, the grantee will be required, as a condition of award, to provide documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP). IRB approval must be received in these cases prior to enrolling clients in the project. General information about Human Subjects Regulations can be obtained through OHRP at http://www.hhs.gov/ohrp, or ohrp@osophs.dhhs.gov, or (240) 453-6900. SAMHSA–specific questions should be directed to the program contact listed in Section VII of this announcement.

2. REVIEW AND SELECTION PROCESS

SAMHSA applications are peer-reviewed according to the review criteria listed above. For those programs where the individual award is over $100,000, applications also must be reviewed by the appropriate National Advisory Council.

Decisions to fund a cooperative agreement are based on:

- the strengths and weaknesses of the application as identified by peer reviewers and, when applicable, approved by the Center for Mental Health Services National Advisory Council; and

- availability of funds.

VI. AWARD ADMINISTRATION INFORMATION

1. AWARD NOTICES

After your application has been reviewed, you will receive a letter from SAMHSA through postal mail that describes the general results of the review, including the score that your application received.

If you are approved for funding, you will receive an **additional** notice, the Notice of Grant Award, signed by SAMHSA's Grants Management Officer. The Notice of Grant Award is the sole obligating document that allows the grantee to receive Federal funding for work on the grant project.

If you are not funded, you may re-apply if there is another receipt date for the program.

2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS

If your application is funded, you must comply with all terms and conditions of the grant award. SAMHSA's standard terms and conditions are available on the SAMHSA Web site at www.samhsa.gov/grants/management.aspx.

If your application is funded, you must also comply with the administrative requirements outlined in 45 CFR Part 74 or 45 CFR Part 92, as appropriate. For more information see the SAMHSA Web site (http://www.samhsa.gov/grants/generalinfo/grant_reqs.aspx).

- Depending on the nature of the specific funding opportunity and/or your proposed project as identified during review, SAMHSA may negotiate additional terms and conditions with you prior to grant award. These may include, for example:
  - actions required to be in compliance with confidentiality and participant protection/human subjects requirements;
  - requirements relating to additional data collection and reporting;
  - requirements relating to participation in a cross-site evaluation; or
  - requirements to address problems identified in review of the application.

- If your application is funded, you will be held accountable for the information provided in the application relating to performance targets. SAMHSA program officials will consider your progress in meeting goals and objectives, as well as your failures and strategies for overcoming them, when making an annual recommendation to continue the grant and the amount of any continuation award. Failure to meet stated goals and objectives may result in suspension or termination of the grant award, or in reduction or withholding of continuation awards.

- Grant funds cannot be used to supplant current funding of existing activities. "Supplant" is defined as replacing funding of a recipient's existing program with funds from a Federal grant.

- In an effort to improve access to funding opportunities for applicants, SAMHSA is participating in the U.S. Department of Health and Human Services "Survey on Ensuring Equal Opportunity for Applicants." This survey is included in the application kit for SAMHSA grants and is posted on the SAMHSA Web site. You are encouraged to complete the survey and return it, using the instructions provided on the survey form.

3. REPORTING REQUIREMENTS

In addition to the data reporting requirements listed in Section I-2.2, you must comply with the following reporting requirements:

3.1 Progress and Financial Reports

- You will be required to submit annual and final progress reports, as well as annual and final financial status reports.

- Because SAMHSA is extremely interested in ensuring that treatment and prevention services can be sustained, your progress reports should explain plans to ensure the sustainability of efforts initiated under this cooperative agreement.

- If your application is funded, SAMHSA will provide you with guidelines and requirements for these reports at the time of award and at the initial grantee orientation meeting after award. SAMHSA staff will use the information contained in the reports to determine your progress toward meeting its goals.

3.2 Government Performance and Results Act

The Government Performance and Results Act (GPRA) mandates accountability and performance-based management by Federal agencies. To meet the GPRA requirements, SAMHSA must collect performance data (i.e., "GPRA data") from grantees. The performance requirements for SAMHSA's Networking, Certifying, and Training Suicide Prevention Hotlines cooperative agreement program are described in Section I-2.2 of this document under "Data Collection and Performance Measurement."

3.3 Publications

If you are funded under this grant program, you are required to notify the Government Project Officer (GPO) and SAMHSA's Publications Clearance Officer (240-276-2130) of any materials based on the SAMHSA-funded project that are accepted for publication.

In addition, SAMHSA requests that the grantee:

- Provide the GPO and SAMHSA Publications Clearance Officer with advance copies of publications.

- Include acknowledgment of the SAMHSA grant program as the source of funding for the project.

- Include a disclaimer stating that the views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services, and should not be construed as such.

SAMHSA reserves the right to issue a press release about any publication deemed by SAMHSA to contain information of program or policy significance to the substance abuse treatment/substance abuse prevention/mental health services community.

VII. AGENCY CONTACTS

For questions about program issues contact:

Richard McKeon, Ph.D., M.P.H.
Special Advisor, Suicide Prevention
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 6-1105
Rockville, Maryland 20857
(240) 276-1873
richard.mckeon@samhsa.hhs.gov

For questions on grants management issues, contact:

Kimberly Pendleton
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1097
Rockville, Maryland 20857
(240) 276-1421
kimberly.pendleton@samhsa.hhs.gov

Appendix A – Checklist for Formatting Requirements and Screenout Criteria for SAMHSA Grant Applications

SAMHSA's goal is to review all applications submitted for grant funding. However, this goal must be balanced against SAMHSA's obligation to ensure equitable treatment of applications. For this reason, SAMHSA has established certain formatting requirements for its applications. ***If you do not adhere to these requirements, your application will be screened out and returned to you without review.***

- ❑ Use the PHS 5161-1 application.

- ❑ Applications must be received by the application deadline or have proof of timely submission, as detailed in Section IV-3 of the grant announcement.

- ❑ Information provided must be sufficient for review.

- ❑ Text must be legible. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-6 of this announcement under "Submission of Electronic Applications.")
    - Type size in the Project Narrative cannot exceed an average of 15 characters per inch, as measured on the physical page. (Type size in charts, tables, graphs, and footnotes will not be considered in determining compliance.)
    - Text in the Project Narrative cannot exceed 6 lines per vertical inch.

- ❑ Paper must be white paper and 8.5 inches by 11.0 inches in size.

- ❑ To ensure equity among applications, the amount of space allowed for the Project Narrative cannot be exceeded. (For Project Narratives submitted electronically in Microsoft Word, see separate requirements in Section IV-6 of this announcement under "Submission of Electronic Applications.")
    - Applications would meet this requirement by using all margins (left, right, top, bottom) of at least one inch each, and adhering to the page limit for the Project Narrative stated in the specific funding announcement.
    - Should an application not conform to these margin or page limits, SAMHSA will use the following method to determine compliance: The total area of the Project Narrative (excluding margins, but including charts, tables, graphs and footnotes) cannot exceed 58.5 square inches multiplied by the page limit. This number represents the full page less margins, multiplied by the total number of allowed pages.
    - Space will be measured on the physical page. Space left blank within the Project Narrative (excluding margins) is considered part of the Project Narrative, in determining compliance.

To facilitate review of your application, follow these additional guidelines. Failure to adhere to the following guidelines will not, in itself, result in your application being screened out and returned without review. However, the information provided in your application must be

sufficient for review. Following these guidelines will help ensure your application is complete, and will help reviewers to consider your application.

- ❑ The 10 application components required for SAMHSA applications should be included. These are:

  - Face Page (Standard Form 424 v2, which is in PHS 5161-1)
  - Abstract
  - Table of Contents
  - Budget Form (Standard Form 424A, which is in PHS 5161-1)
  - Project Narrative and Supporting Documentation
  - Appendices
  - Assurances (Standard Form 424B, which is in PHS 5161-1)
  - Certifications (a form within PHS 5161-1)
  - Disclosure of Lobbying Activities (Standard Form LLL, which is in PHS 5161-1)
  - Checklist (a form in PHS 5161-1)

- ❑ Applications should comply with the following requirements:

  - Provisions relating to confidentiality and participant protection specified in Section V-1 of this announcement.
  - Budgetary limitations as specified in Section I, II, and IV-5 of this announcement.
  - Documentation of nonprofit status as required in the PHS 5161-1.

- ❑ Pages should be typed single-spaced in black ink, with one column per page. Pages should not have printing on both sides.

- ❑ Please number pages consecutively from beginning to end so that information can be located easily during review of the application. The cover page should be page 1, the abstract page should be page 2, and the table of contents page should be page 3. Appendices should be labeled and separated from the Project Narrative and budget section, and the pages should be numbered to continue the sequence.

- ❑ The page limits for Appendices stated in the specific funding announcement should not be exceeded.

- ❑ Send the original application and two copies to the mailing address in Section IV-6 of this document. Please do not use staples, paper clips, and fasteners. Nothing should be attached, stapled, folded, or pasted. Do not use heavy or lightweight paper or any material that cannot be copied using automatic copying machines. Odd-sized and oversized attachments such as posters will not be copied or sent to reviewers. Do not include videotapes, audiotapes, or CD-ROMs.

Appendix B – Guidance for Electronic Submission of Applications

If you would like to submit your application electronically, you may search www.Grants.gov for the downloadable application package by the funding announcement number (called the opportunity number) or by the Catalogue of Federal Domestic Assistance (CFDA) number. You can find the CFDA number on the first page of the funding announcement.

You must follow the instructions in the User Guide available at the www.Grants.gov apply site, on the Help page. In addition to the User Guide, you may wish to use the following sources for help:

- By e-mail: support@Grants.gov
- By phone: 1-800-518-4726 (1-800-518-GRANTS). The Customer Support Center is open from 7:00 a.m. to 9:00 p.m. Eastern Time, Monday through Friday, excluding Federal holidays.

If this is the first time you have submitted an application through Grants.gov, you must complete four separate registration processes before you can submit your application. Allow at least two weeks (10 business days) for these registration processes, prior to submitting your application. The processes are: 1) DUNS Number registration; 2) Central Contractor Registry (CCR) registration; 3) Credential Provider registration; and 4) Grants.gov registration.

It is strongly recommended that you submit your grant application using Microsoft Office products (e.g., Microsoft Word, Microsoft Excel, etc.). If you do not have access to Microsoft Office products, you may submit PDF files. Directions for creating PDF files can be found on the Grants.gov Web site. Use of file formats other than Microsoft Office or PDF may result in your file being unreadable by our staff.

The Project Narrative must be a separate document in the electronic submission. Formatting requirements for SAMHSA grant applications are described in Appendix A of this announcement. These requirements also apply to applications submitted electronically, with the following exceptions only for Project Narratives submitted electronically in Microsoft Word. These requirements help ensure the accurate transmission and equitable treatment of applications.

- *Text legibility*: Use a font of Times New Roman 12, line spacing of single space, and all margins (left, right, top, bottom) of one inch each. Adhering to these standards will help to ensure the accurate transmission of your document. If the type size in the Project Narrative of an electronic submission exceeds 15 characters per inch, or the text exceeds 6 lines per vertical inch, SAMHSA will reformat the document to Times New Roman 12, with line spacing of single space. Please note that this may alter the formatting of your document, especially for charts, tables, graphs, and footnotes.

- *Amount of space allowed for Project Narrative*: The Project Narrative for an electronic submission may not exceed 12,875 words. If the Project Narrative for an electronic submission exceeds the word limit and exceeds the allowed space as defined in Appendix

A, then **any part of the Project Narrative in excess of these limits will not be submitted to review**. To determine the number of words in your Project Narrative document in Microsoft Word, select file/properties/statistics.

While keeping the Project Narrative as a separate document, please consolidate all other materials in your application to ensure the fewest possible number of attachments. Ensure all pages in your application are numbered consecutively, with the exception of the standard forms in the PHS-5161 application package. Please name and number your attachments, indicating the order in which they should be assembled. Failure to comply with these requirements may affect the successful transmission and consideration of your application.

Applicants are strongly encouraged to submit their applications to Grants.gov early enough to resolve any unanticipated difficulties prior to the deadline. You may also submit a back-up paper submission of your application. Any such paper submission must be received in accordance with the requirements for timely submission detailed in Section IV-3 of this announcement. The paper submission must be clearly marked: **"Back-up for electronic submission."** The paper submission must conform with all requirements for non-electronic submissions. If both electronic and back-up paper submissions are received by the deadline, the electronic version will be considered the official submission.

After you electronically submit your application, you will receive an automatic acknowledgement from Grants.gov that contains a Grants.gov tracking number. It is important that you retain this number. **Include the Grants.gov tracking number in the top right corner of the face page for any paper submission. Receipt of the tracking number is the only indication that Grants.gov has successfully received and validated your application. If you do not receive a Grants.gov tracking number, you may want to contact the Grants.gov help desk for assistance.**

The Grants.gov Web site does not accept electronic signatures at this time. Therefore, you must submit a signed paper original of the face page (SF 424 v2), the assurances (SF 424B), and hard copy of any other required documentation that cannot be submitted electronically. **You must include the Grants.gov tracking number for your application on these documents with original signatures, on the top right corner of the face page, and send the documents to the following address. The documents must be received at the following address within 5 business days after your electronic submission.** Delays in receipt of these documents may impact the score your application receives or the ability of your application to be funded.

For United States Postal Service:

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD **20857**
ATTN: Electronic Applications

For other delivery services, change the zip code to 20850.

If you require a phone number for delivery, you may use (240) 276-1199.

Appendix C - Glossary

Best Practice: Best practices are practices that incorporate the best objective information currently available regarding effectiveness and acceptability.

Cooperative Agreement: A cooperative agreement is a form of Federal grant. Cooperative agreements are distinguished from other grants in that, under a cooperative agreement, substantial involvement is anticipated between the awarding office and the recipient during performance of the funded activity. This involvement may include collaboration, participation, or intervention in the activity. HHS awarding offices use grants or cooperative agreements (rather than contracts) when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

Grant: A grant is the funding mechanism used by the Federal Government when the principal purpose of the transaction is the transfer of money, property, services, or anything of value to accomplish a public purpose of support or stimulation authorized by Federal statute. The primary beneficiary under a grant or cooperative agreement is the public, as opposed to the Federal Government.

Practice: A practice is any activity, or collective set of activities, intended to improve outcomes for people with or at risk for substance abuse and/or mental illness. Such activities may include direct service provision, or they may be supportive activities, such as efforts to improve access to and retention in services, organizational efficiency or effectiveness, community readiness, collaboration among stakeholder groups, education, awareness, training, or any other activity that is designed to improve outcomes for people with or at risk for substance abuse or mental illness.

Stakeholder: A stakeholder is an individual, organization, constituent group, or other entity that has an interest in and will be affected by a proposed grant project.

Target Population: The target population is the specific population of people whom a particular program or practice is designed to serve or reach. For the purposes of this grant, the target population is the total potential number of suicidal persons who might seek help through hotline services in the United States.

Appendix D – Confidentiality and Participant Protection

1. Protect Clients and Staff from Potential Risks

   - Identify and describe any foreseeable physical, medical, psychological, social, and legal risks or potential adverse effects as a result of the project itself or any data collection activity.

   Describe the procedures you will follow to minimize or protect participants against potential risks, **including risks to confidentiality**.

   Identify plans to provide guidance and assistance in the event there are adverse effects to participants.

   Where appropriate, describe alternative treatments and procedures that may be beneficial to the participants. If you choose not to use these other beneficial treatments, provide the reasons for not using them.

2. Fair Selection of Participants

   - Describe the target population(s) for the proposed project. Include age, gender, and racial/ethnic background and note if the population includes homeless youth, foster children, children of substance abusers, pregnant women, or other targeted groups.

   - Explain the reasons for including groups of pregnant women, children, people with mental disabilities, people in institutions, prisoners, and individuals who are likely to be particularly vulnerable to HIV/AIDS.

   - Explain the reasons for including or excluding participants.

   - Explain how you will recruit and select participants. Identify who will select participants.

3. Absence of Coercion

   - Explain if participation in the project is voluntary or required. Identify possible reasons why participation is required, for example, court orders requiring people to participate in a program.

   - If you plan to compensate participants, state how participants will be awarded incentives (e.g., money, gifts, etc.).

   - State how volunteer participants will be told that they may receive services intervention even if they do not participate in or complete the data collection component of the project.

4. Data Collection

   - Identify from whom you will collect data (e.g., from participants themselves, family members, teachers, others). Describe the data collection procedures and specify the sources for obtaining data (e.g., school records, interviews, psychological assessments, questionnaires, observation, or other sources). Where data are to be collected through observational techniques, questionnaires, interviews, or other direct means, describe the data collection setting.

   - Identify what type of specimens (e.g., urine, blood) will be used, if any. State if the material will be used just for evaluation or if other use(s) will be made. Also, if needed, describe how the material will be monitored to ensure the safety of participants.

   - Provide in **Appendix 2, "Data Collection Instruments/Interview Protocols,"** copies of all available data collection instruments and interview protocols that you plan to use.

5. Privacy and Confidentiality

   - Explain how you will ensure privacy and confidentiality. Include who will collect data and how it will be collected.

   - Describe:

     - How you will use data collection instruments.
     - Where data will be stored.
     - Who will or will not have access to information.
     - How the identity of participants will be kept private, for example, through the use of a coding system on data records, limiting access to records, or storing identifiers separately from data.

NOTE: If applicable, grantees must agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of **Title 42 of the Code of Federal Regulations, Part II.**

6. Adequate Consent Procedures

   - List what information will be given to people who participate in the project. Include the type and purpose of their participation. Identify the data that will be collected, how the data will be used and how you will keep the data private.

   - State:

     - Whether or not their participation is voluntary.
     - Their right to leave the project at any time without problems.
     - Possible risks from participation in the project.
     - Plans to protect clients from these risks.

- Explain how you will get consent for youth, the elderly, people with limited reading skills, and people who do not use English as their first language.

NOTE: If the project poses potential physical, medical, psychological, legal, social or other risks, you **must** obtain written informed consent.

- Indicate if you will obtain informed consent from participants or assent from minors along with consent from their parents or legal guardians. Describe how the consent will be documented. For example: Will you read the consent forms? Will you ask prospective participants questions to be sure they understand the forms? Will you give them copies of what they sign?

- Include, as appropriate, sample consent forms that provide for: (1) informed consent for participation in service intervention; (2) informed consent for participation in the data collection component of the project; and (3) informed consent for the exchange (releasing or requesting) of confidential information. The sample forms must be included in **Appendix 3, "Sample Consent Forms"**, of your application. If needed, give English translations.

NOTE: Never imply that the participant waives or appears to waive any legal rights, may not end involvement with the project, or releases your project or its agents from liability for negligence.

- Describe if separate consents will be obtained for different stages or parts of the project. For example, will they be needed for both participant protection in treatment intervention and for the collection and use of data?

- Additionally, if other consents (e.g., consents to release information to others or gather information from others) will be used in your project, provide a description of the consents. Will individuals who do not consent to having individually identifiable data collected for evaluation purposes be allowed to participate in the project?

7. Risk/Benefit Discussion

   Discuss why the risks are reasonable compared to expected benefits and importance of the knowledge from the project.

Protection of Human Subjects Regulations

Applicants may also have to comply with the Protection of Human Subjects Regulations (45 CFR 46), depending on the evaluation and data collection procedures proposed and the population to be served.

Applicants must be aware that even if the Protection of Human Subjects Regulations do not apply to all projects funded, the specific evaluation design proposed by the applicant may require compliance with these regulations.

Applicants whose projects must comply with the Protection of Human Subjects Regulations must describe the process for obtaining Institutional Review Board (IRB) approval fully in their applications. While IRB approval is not required at the time of grant award, these applicants will be required, as a condition of award, to provide the documentation that an Assurance of Compliance is on file with the Office for Human Research Protections (OHRP) and that IRB approval has been received prior to enrolling any clients in the proposed project.

General information about Protection of Human Subjects Regulations can be obtained on the Web at http://www.hhs.gov/ohrp. You may also contact OHRP by e-mail (ohrp@osophs.dhhs.gov) or by phone (240/453-6900). SAMHSA-specific questions related to Protection of Human Subjects Regulations should be directed to the program contact listed in Section VII of this RFA.

Appendix E – Sample Budget and Justification

ILLUSTRATION OF A SAMPLE DETAILED BUDGET AND NARRATIVE JUSTIFICATION TO ACCOMPANY SF 424A: SECTION B FOR 01 BUDGET PERIOD

OBJECT CLASS CATEGORIES

Personnel

Job Title	Name	Annual Salary	Level of Effort	Salary being Requested
Project Director	J. Doe	$30,000	1.0	$30,000
Secretary	Unnamed	$18,000	0.5	$ 9,000
Counselor	R. Down	$25,000	1.0	$25,000

Enter Personnel subtotal on 424A, Section B, 6.a. **$64,000**

Fringe Benefits (24%) $15,360

Enter Fringe Benefits subtotal on 424A, Section B, 6.b. **$15,360**

Travel

2 trips for SAMHSA Meetings for 2 Attendees (Airfare @ $600 x 4 = $2,400) + (per diem @ $120 x 4 x 6 days = $2,880)	$5,280
Local Travel (500 miles x .24 per mile)	120

[Note: Current Federal Government per diem rates are available at www.gsa.gov.]

Enter Travel subtotal on 424A, Section B, 6.c. **$ 5,400**

Equipment (List Individually)

"Equipment" means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals the lesser of (a) the capitalization level established by the governmental unit or nongovernmental applicant for financial statement purposes, or (b) $5000.

Enter Equipment subtotal on 424A, Section B, 6.d.

Supplies

Office Supplies	$500
Computer Software - 1 WordPerfect	500

Enter Supplies subtotal on 424A, Section B, 6.e. **$1,000**

Contractual Costs

Evaluation

Job Title	Name	Annual Salary	Salary being Requested	Level of Effort
Evaluator	J. Wilson	$48,000	$24,000	0.5
Other Staff		$18,000	$18,000	1.0
Fringe Benefits (25%)		$10,500		

Travel

2 trips x 1 Evaluator ($600 x 2)	$ 1,200	
per diem @ $120 x 6	720	
Supplies (General Office)	500	
Evaluation Direct		$54,920
Evaluation Indirect Costs (19%)		$10,435
Evaluation Subtotal		$65,355

Training

Job Title	Name	Level of Effort	Salary being Requested
Coordinator	M. Smith	0.5	$ 12,000
Admin. Asst.	N. Jones	0.5	$ 9,000
Fringe Benefits (25%)			$ 5,250

Travel

2 Trips for Training	
Airfare @ $600 x 2	$ 1,200
Per Diem $120 x 2 x 2 days	480
Local (500 miles x .24/mile)	120

Supplies

Office Supplies	$ 500
Software (WordPerfect)	500

Other

Rent (500 Sq. Ft. x $9.95)	$ 4,975
Telephone	500
Maintenance (e.g., van)	$ 2,500
Audit	$ 3,000

Training Direct	$ 40,025
Training Indirect	$ -0-

Enter Contractual subtotal on 424A, Section B, 6.f. $105,380

ILLUSTRATION OF DETAILED BUDGET AND NARRATIVE JUSTIFICATION (cont'd.)

Other

Consultants = Expert @ $250/day X 6 day (If expert is known, should list by name)	$ 1,500
Enter Other subtotal on 424A, Section B, 6.h.	**$ 1,500**
Total Direct Charges (sum of 6.a-6.h) **Enter Total Direct on 424A, Section B, 6.i.**	**$192,640**

Indirect Costs

15% of Salary and Wages (copy of negotiated indirect cost rate agreement attached)	
Enter Indirect subtotal of 424A, Section B, 6.j.	**$ 9,600**

TOTALS

Enter TOTAL on 424A, Section B, 6.k.	**$202,240**

JUSTIFICATION

PERSONNEL - Describe the role and responsibilities of each position.

FRINGE BENEFITS - List all components of the fringe benefit rate.

EQUIPMENT - List equipment and describe the need and the purpose of the equipment in relation to the proposed project.

SUPPLIES - Generally self-explanatory; however, if not, describe need. Include explanation of how the cost has been estimated.

TRAVEL - Explain need for all travel other than that required by SAMHSA.

CONTRACTUAL COSTS - Explain the need for each contractual arrangement and how these components relate to the overall project.

OTHER - Generally self-explanatory. If consultants are included in this category, explain the need and how the consultant's rate has been determined.

INDIRECT COST RATE - If your organization has no indirect cost rate, please indicate whether your organization plans to a) waive indirect costs if an award is issued, or b) negotiate and establish an indirect cost rate with DHHS within 90 days of award issuance.

CALCULATION OF FUTURE BUDGET PERIODS
(based on first 12-month budget period)

Review and verify the accuracy of future year budget estimates. Increases or decreases in the future years must be explained and justified and no cost of living increases will be honored. (NOTE: new salary cap of $186,600 is effective for all FY 2007 awards.) *

	First 12-month Period	Second 12-month Period	Third 12-month Period
Personnel			
Project Director	30,000	30,000	30,000
Secretary**	9,000	18,000	18,000
Counselor	25,000	25,000	25,000
TOTAL PERSONNEL	64,000	73,000	73,000

*Consistent with the requirement in the Consolidated Appropriations Act, Public Law 108-447.
**Increased from 50% to 100% effort in 02 through 03 budget periods.

Fringe Benefits (24%)	15,360	17,520	17,520
Travel	5,400	5,400	5,400
Equipment	-0-	-0-	-0-
Supplies***	1,000	520	520

***Increased amount in 01 year represents costs for software.

Contractual			
Evaluation****	65,355	67,969	70,688
Training	40,025	40,025	40,025

****Increased amounts in 02 and 03 years are reflected of the increase in client data collection.

Other	1,500	1,500	1,500
Total Direct Costs	192,640	205,934	208,653
Indirect Costs (15% S&W)	9,600	9,600	9,600
TOTAL COSTS	202,240	216,884	219,603

The Federal dollars requested for all object class categories for the first 12-month budget period are entered on Form 424A, Section B, Column (1), lines 6a-6i. The total Federal dollars requested for the second through the fifth 12-month budget periods are entered on Form 424A, Section E, Columns (b) – (e), line 20. The RFA will specify the maximum number of years of support that may be requested.

ATTACHMENT E

LIST OF 149 CRISIS CENTERS PARTICIPATING IN THE NATIONAL SUICIDE PREVENTION LIFELINE NETWORK

NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Participating Crisis Centers

with signed network agreement on record as of 2/8/2011

NATIONAL SUICIDE PREVENTION LIFELINE

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Participating crisis centers with signed network agreement

Careline Crisis Intervention Fairbanks, AK

Lifelines East Mobile, AL

Crisis Services of North Alabama/HELPline Huntsville, AL

Crisis Center Birmingham, AL

Northwest Arkansas Crisis Center Springdale, AR

EMPACT Suicide Prevention Center Tempe, AZ

Southern Arizona Mental Health Corporation DBA SAMHC Tucson, AZ

Kern County Mental Health Bakersfield, CA

Crisis Support Services of Alameda County Oakland, CA

The Effort Sacramento, CA

Suicide Prevention and Community Counseling San Rafael, CA

Youth and Family Enrichment Services, Suicide Prevention and Crisis Intervention Center San Mateo, CA

Suicide Prevention Center, Didi Hirsch Mental Health Services Los Angeles, CA

San Francisco Suicide Prevention San Francisco, CA

Contra Costa Crisis Center Walnut Creek, CA

Pueblo Suicide Prevention Center Pueblo, CO

2-1-1/United Way of Connecticut Rocky Hill, CT

Wheeler Clinic Plainville, CT

DC Department of Mental Health Washington, DC

ContactLifeline Wilmington, DE

2-1-1 Heart of Florida United Way Orlando, FL

2-1-1 Big Bend Tallahassee, FL

211 Brevard Cocoa, FL

2-1-1 Tampa Bay Cares Clearwater, FL

Stewart-Marchman-Act Behavioral Healthcare Daytona Beach, FL

Alachua County Crisis Center Gainesville, FL

Crisis Center of Tampa Bay, Inc. Tampa, FL

Personal Enrichment through Mental Health Services Pinellas Park, FL

Switchboard of Miami Miami, FL

211 Palm Beach/ Treasure Coast Lantana, FL

United Way 211 Jacksonville, FL

Behavioral Health Link Atlanta, GA

ACCESS Line Honolulu, HI

Foundation 2 Crisis Center Cedar Rapids, IA

Path Crisis Center Bloomington, IL

Call for Help, Suicide and Crisis Hotline Edgemont, IL

Community Counseling Centers of Chicago Chicago, IL

Mental Health Association of Illinois Valley Peoria, IL

Suicide Prevention Services Batavia, IL

Participating crisis centers with signed network agreement

Crisis Line Of Will County Joliet, IL
Janet Wattles Mental Health Center Rockford, IL
Lafayette Crisis Center Lafayette, IN
A Better Way Services Muncie, IN
Mental Health America in Greater Indianapolis Indianapolis, IN
Crisis Contact Gary, IN
Connect2Help Indianapolis, IN
Headquarters Counseling Center Lawrence, KS
Four Rivers Behavioral Health Mayfield, KY
Crisis Line, RiverValley Behavioral Health Owensboro, KY
Crisis and Information Center, Seven Counties Services Louisville, KY
Baton Rouge Crisis Intervention Center Baton Rouge, LA
VIA LINK Call Center New Orleans, LA
The Samaritans of Fall River/New Bedford Westport, MA
Boston Emergency Services Boston, MA
The Samaritans of Boston Boston, MA
Life Crisis Center Salisbury, MD
Baltimore Crisis Response Baltimore, MD
Mental Health Association of Montgomery County Rockville, MD
Community Crisis Services Hyattsville, MD
Frederick County Hotline Frederick, MD
Grassroots Crisis Intervention Center Columbia, MD
Crisis and Counseling Augusta, ME
Network 180 Grand Rapids, MI
Neighborhood Service Organization Detroit, MI
Common Ground Bloomfield Hills, MI
Dial Help Houghton, MI
Gryphon Place Kalamazoo, MI
Macomb County Crisis Center Chesterfield, MI
Third Level Crisis Intervention Center Traverse City, MI
Crisis Connection Richfield, MN
Life Crisis Services St. Louis, MO
Behavioral Health Response St. Louis, MO
Mississippi Department of Mental Health - Office of Constituency Services Jackson, MS
CONTACT Helpline Columbus, MS
The Help Center Bozeman, MT
Voices of Hope Great Falls, MT
REAL Crisis Intervention Greenville, NC
NC DHHS OCS CARE-LINE Raleigh, NC

Participating crisis centers with signed network agreement

FirstLink HotLine Fargo, ND

Boys Town National Hotline Boys Town, NE

Headrest Lebanon, NH

CONTACT of Burlington County Moorestown, NJ

CONTACT of Mercer County Ewing, NJ

CONTACT We Care Westfield, NJ

Crisis Response of Santa Fe Santa Fe, NM

Agora Crisis Center Albuquerque, NM

Crisis Call Center Reno, NV

2-1-1/LIFE LINE - A Program of ABVI-Goodwill Rochester, NY

Covenant House Nineline New York, NY

Crisis Services Buffalo, NY

Long Island Crisis Center Bellmore, NY

Suicide Prevention and Crisis Service of Tompkins County Ithaca, NY

Dutchess County Department of Mental Hygiene - HELPLINE Poughkeepsie, NY

LifeNet New York, NY

Samaritans Crisis Hotline Albany, NY

Response of Suffolk County Stony Brook, NY

We Care Regional Crisis Center Lima, OH

281-Care Centerpoint Health Cincinnati, OH

Pathways of Central Ohio Newark, OH

Community Counseling and Crisis Center Oxford, OH

Trumbull 2-1-1 Warren, OH

Crisis Intervention and Recovery Center Canton, OH

Help Hotline Crisis Center Youngstown, OH

HelpLIne of Delaware and Morrow Counties Delaware, OH

Mental Health Services Cleveland, OH

North Central Mental Health Services Columbus, OH

Rescue Incorporated Toledo, OH

Portage Path Behavioral Akron, OH

Family & Children's Services Tulsa, OK

Heartline Oklahoma City, OK

Oregon Partnership Alcohol and Drug Helpline and YouthLIne Portland, OR

re:solve Crisis Network Pittsburgh, PA

CONTACT Beaver Valley Beaver, PA

CONTACT Greater Philadelphia Richboro, PA

CONTACT Lancaster Helpline Lancaster, PA

CONTACT Greater Philadelphia Wynnewood, PA

Adams Hanover Counseling Services Hanover, PA

Participating crisis centers with signed network agreement

Center for Community Resources Butler, PA

Gateway/Community Counseling Center Pawtucket, RI

CRISISline - Mental Health America of Greenville County Greenville, SC

211 Hotline N. Charleston, SC

HELP!Line Center Sioux Falls, SD

Peninsula Mobile Responses Team (a division of Parkwest Medical Center) Knoxville, TN

Centerstone Customer Care & Crisis Call Center Nashville, TN

Frontier Health Mobile Crisis Response/Watauga Behavioral Health Services Johnson City, TN

The Crisis Center Memphis, TN

Volunteer Crisis Services, Volunteer Behavioral Health Chattanooga, TN

Behavioral Health Initiatives Jackson, TN

Intake & Crisis Emergency Services of El Paso MHMR El Paso, TX

CONTACT Crisis Line Dallas, TX

MHMRA Helpline Houston, TX

Suicide and Crisis Center Dallas, TX

Crisis Intervention of Houston Houston, TX

Valley Mental Health Salt Lake City, UT

Crisis Line of Central Virginia Lynchburg, VA

CrisisLink Arlington, VA

The Crisis Center Bristol, VA

Helpline ACTS Dumfries, VA

Vermont 2-1-1 Essex Junction, VT

Volunteers of America/Crisis Response Services Everett, WA

Crisis Clinic of the Peninsulas Bremerton, WA

Acute Care Services - Crisis Intervention Team West Bend, WI

Crisis Center of Family Services Green Bay, WI

Emergency Services Unit - MH Ctr of Dane Co. Madison, WI

Mental Health Association in Waukesha County, Inc. Waukesha, WI

Milwaukee County Behavioral Health Division Wauwatosa, WI

North Central Health Care Facilities Wausau, WI

Valley HealthCare System Morgantown, WV

Wyoming Behavioral Institute Casper, WY

ATTACHMENT F

DECISION OF THE HHS DEPARTMENT APPEALS BOARD IN THE MATTER OF AMERICAN ASSOCIATION OF SUICIDOLOGY/ KRISTIN BROOKS HOPE CENTER DECISION NO. 2108, AUGUST 22, 2007

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: American Association of Suicidology
Docket No. A-07-44
Decision No. 2108

DATE: August 22, 2007

DECISION

The American Association of Suicidology (AAS), through the Kristin Brooks Hope Center (KBHC), appealed a decision by the Substance Abuse and Mental Health Services Administration (SAMHSA) disallowing claims for reimbursement filed by AAS on behalf of KBHC. KBHC claimed these funds as a subrecipient under a cooperative agreement (SAMHSA Grant No. SM54127) awarded by SAMHSA to AAS pursuant to section 520(a) of the Public Health Service Act. The total amount in dispute in this appeal is $190,236.

Based on the evidence and arguments presented in this appeal, we uphold this disallowance.

Applicable Law

As a non-profit organization and subrecipient of federal funds under this cooperative agreement, KBHC is subject to the uniform administrative requirements set forth at 45 C.F.R. Part 74. 45 C.F.R. §§ 74.1(a), 74.5. Additionally, KBHC is subject to the cost principles set forth in Office of Management and Budget (OMB) Circular A-122, *Cost Principles for Non-Profit Organizations,* located at 2 C.F.R. Part 230 and made applicable by 45 C.F.R. § 74.27(a). Finally, this agreement, by its own terms, is subject to the Public Health Service Grants Policy Statement. SAMHSA Ex. 1, at 1. These authorities require, among other things, that costs charged to federal awards be reasonable, necessary, allocable, adequately documented. See e.g. OMB Circular A-122, Att. A, ¶ A.2. Specifically, 45 C.F.R. § 74.21(b)(7) requires that grantees have "accounting records, including cost accounting records, that are supported by source documentation."

When a cost is disallowed by the grantor agency, the burden is on the grantee to prove, with appropriate documentation, that the cost is allowable under the cost principles and other relevant program requirements. Marie Detty Youth and Family Services Center, Inc., DAB No. 2024 (2006); Northstar Youth Services, DAB No. 1884 (2003).

Background

At all times relevant herein, KBHC was a non-profit organization committed to suicide prevention and the founder and operator of the Hopeline Network at 1-800-SUICIDE. The Hopeline Network is a national suicide prevention telephone hotline that links crisis centers certified in suicide prevention. KBHC Ex. C, at 4, 16.

In 2001, SAMHSA entered into a three-year cooperative agreement with AAS under section 520(a) of the Public Health Service Act.[1] SAMHSA Ex. 1; KBHC Ex. D. The Notice of Grant Award identified AAS as the grantee and AAS's executive director as the director of the project (Project Director). SAMHSA Ex. 1, at 1.

The purposes of the grant were to "increase the number of crisis centers/hotlines certified in suicide prevention," to "increase the number of crisis programs offering hotline services that are certified in suicide prevention which are networked through a single, nationally accessible telephone number," and to "coordinate, collect and analyze outcome data for a number of

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[1] Section 74.11(a) of 45 C.F.R. discusses the distinction between a grant and a cooperative agreement made by the Federal Grant and Cooperative Agreement Act, 31 U.S.C. §§ 6301-08. It states -

> [t]he statutory criteria for choosing between grants and cooperative agreement is that for the latter, 'substantial involvement is expected between the executive agency and the . . . recipient when carrying out the activity contemplated in the agreement.

Because the parties use the term 'grant' in referring to this cooperative agreement and because a cooperative agreement is treated like a grant for purposes of the applicable requirements, we use that term. The fact that the award was a cooperative agreement is relevant, however, since it justifies SAMHSA's greater involvement in determining what project activities would be funded.

specifically identified crisis programs in order to evaluate their effectiveness." KBHC Ex. D, at 9.

In its application to SAMHSA, AAS identified KBHC as a subcontractor under the grant. KBHC Ex. C, at 16; see also SAMHSA Ex. 2 (Subcontract Proposal Factsheet).[2] The application set forth tasks to be performed by AAS and by KBHC, and separate staffing plans and budget justifications for both organizations. KBHC Ex. C, at 15, 19-20, 25-28.

"Over the course of the grant," KBHC represents, "the relationship between and among SAMHSA, AAS, and KBHC became strained. Disputes over payment responsibilities, proper roles, and authorized activities became increasingly frequent . . . ." KBHC Br. at 3. This strain is apparent from the following evidence in the record, which provides relevant context to the dispute before us and explains how KBHC came to represent AAS in this appeal.

- KBHC was not fulfilling one of its principal tasks under the grant -- enrolling additional crisis centers in the 1-800-SUICIDE network call system. Under the grant's goals, KBHC was to enroll 80 centers in Year 1, 70 in Year 2 and 50 in Year 3. KBHC C, at 15, as modified in KBHC Ex. E, at 16. However, it is apparent from AAS's correspondence with KBHC that, as of April of Year 2, this goal was far from being met. See KBHC Ex. F, at 3.

- Under the terms of the grant, KBHC was authorized to support only part of its operation with grant funds. See KBHC Ex. C, at 26-28 ; KBHC Ex. F, at 4 (stating, for each job position, the percent of salary to be covered by the grant). In applying for the award, KBHC made representations about its intention and ability to secure independent funding for itself and the 1-800-SUICIDE network, both during the award period and subsequently. See KBHC Ex. C, at 18; Ex. E, at 13-14. It is apparent from the record that, as of April 2003, those intentions had not been realized. See KBHC Ex.

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[2] In its Response Brief, SAMHSA argued that KBHC was a "subcontractor" under the grant. SAMHSA Response Br. at 5. Citing the definition of "subaward" at 45 C.F.R. § 74.2, KBHC responded that the relationship between AAS and KBHC was based on a subaward. KBHC Reply Br. at 2. From the record before us, it appears that KBHC received a subaward of this grant from AAS and was a subrecipient, as that term is defined in 45 C.F.R. § 74.2. KBHC Exs. C; E.

F, at 5. AAS determined KBHC had spent restricted funds (i.e., grant funds) for unrestricted expenses and requested KBHC to adopt "procedural safeguards . . . to prevent all possibility of further misappropriation." Id.

- To address KBHC's funding problems, AAS authorized 100% support from the grant for KBHC from May 1 to July 1, 2003 so that KBHC could "aggressively implement" a development plan to generate funds to pay for expenses that were not funded by the grant. Id. Thereafter, AAS again restricted the share of KBHC expenses that were to be funded by the grant. Id. at 5-6. Such restriction was consistent with the terms of the grant, which provided for only partial support of KBHC's total activities, whether or not they could be viewed as furthering the purposes of the grant. KBHC Ex. C, at 26-27.

- SAMHSA established a formal process for payment whereby KBHC submitted invoices to AAS with a request for payment and AAS would review and approve or deny (with explanation); KBHC could appeal denied payments to SAMHSA by submitting a letter to AAS that AAS would forward to SAMHSA. KBHC Ex. I, at 1. KBHC does not dispute the statement of the Project Director that "Mr. Butler [KBHC's Executive Director] has been informed of this procedure many times, but has rarely followed it." Id.

- On March 24, 2004, SAMHSA issued a Revised Notice of Grant Award placing the grant on high risk status and stating that "the funds [are] restricted and may not be used without the prior approval of [SAMHSA]." SAMHSA Ex. 4, at 2. On April 23, 2004, SAMHSA notified AAS that AAS was not in compliance with the terms of the grant agreement because KBHC had fired all of its staff but its Executive Director, Reese Butler, and both AAS and KBHC had entered into contracts for work under the grant without seeking SAMHSA prior approval. KBHC Ex. H. SAMHSA placed additional specific restrictions on the grant while it "conduct[ed] a complete review of the activities and expenditures of this grant." Id. at 2.

- By July 16, 2004, the communications over this grant had become so disruptive that SAMHSA informed AAS that future contact was to be in "writing, allocating at least two weeks for response." KBHC Ex. I, at 12.

- As of March 2005, KBHC had sued AAS in the District of Columbia Superior Court for $285,205.94. Id. at 1.

In July 2005, KBHC and AAS settled the litigation by executing a "Claim and Appeal Agreement" wherein "AAS authorized KBHC to pursue its claims for reimbursement in AAS's name and directly to SAMHSA." KBHC Br. at 5, citing KBHC Ex. B. On September 15, 2006, AAS, on behalf of KBHC, submitted to SAMHSA a list of costs, totaling $424,067, for reimbursement. KBHC Ex. A, at 5-10. On September 22, 2006, SAMHSA denied some of these costs but agreed to review the remainder if KBHC submitted additional documentation. Id. at 11-14. KBHC did so. On December 13, SAMHSA issued a final decision in which it disallowed all but $7,895 of the $424,067 claimed. Id. at 1.

KBHC filed this appeal as to $190,236 of the disallowed costs.[3]

Discussion

A. We deny SAMHSA's request to dismiss this action.

In its Response Brief, SAMHSA for the first time requested the Board to dismiss KBHC's appeal on the ground that the appeal does not meet the requirements of 45 C.F.R. §§ 16.3 and 16.16(a). SAMHSA Response Br. at 15-16.

These sections address, among other things, who may initiate and participate in an appeal before the Board. Section 16.3(a) provides that an appellant must have received a final written determination involving a program that uses the Board for dispute resolution. Such a determination was provided to KBHC's counsel by SAMHSA (at KBHC Ex. A, at 1-4) in response to reimbursement requests he submitted to SAMHSA "by [AAS] on behalf of [KBHC]" (Id. at 5). When KBHC filed the appeal, it stated that "per the instructions in the Agency's determination letter" it was appealing SAMHSA's disallowance "as a subrecipient of [AAS]" and that "AAS, as the grantee, has authorized KBHC to pursue this appeal in its name." Appeal letter dated January 1, 2007. With the appeal file, KBHC filed the "Claims and Appeal Agreement" executed by AAS that authorized KBHC to present KBHC's claims for reimbursement directly to SAMHSA and to appeal SAMHSA's determination to the Board. KBHC Ex. B. Thus, KBHC's role here is as an authorized representative of AAS, the award recipient with the right to appeal.

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[3] The record of this case consists of: KBHC's initial brief (KBHC Br.) and an appeal file containing exhibits labeled A through O; SAMHSA's response brief (SAMHSA Response Br.) and an appeal file containing numbered exhibits 1 through 23; and KBHC's reply brief (KBHC Reply Br.) and one additional exhibit (P).

We also note that section 16.16(a) provides that, "if the Board determines that a third person is the real party in interest . . . the Board may allow the third person to present the case on appeal for the appellant." KBHC has demonstrated that it is a real party in interest because it is undisputed that the appeal involves funds allegedly expended or obligations allegedly incurred by KBHC, not AAS, under this grant. Therefore, this appeal is properly before the Board because it meets the requirements of 45 C.F.R. §§ 16.3 and 16.16(a).

B. We uphold SAMHSA's disallowance of the costs at issue.

The categories of costs at issue on appeal are (1) $73,760 for space and support services provided to KBHC by the National Mental Health Association (NMHA), (2) $982 for forwarding KBHC's Verizon telephone and fax line to the NMHA location, (3) $53,625 for hotel expenses associated with a conference, (4) $1,121 for shipping an exhibit to a conference, (5) $4,408 for unemployment compensation for terminated KBHC employees, (6) $2,340 for expenses for telephone conference calls, and (7) $54,000 for services provided by an independent contractor. Below we discuss why we uphold the disallowance of each of these costs.

1. Costs for office space and administrative support services provided by the NMHA

SAMHSA disallowed $73,760 claimed by KBHC as owed to the NMHA. KBHC Ex. A, at 11. According to KBHC, these costs were incurred for "three months of administrative and general support services contracted for the period April 2004-December 2004 to maintain the essential administrative and support operations." KBHC Ex. A, at 6; see also SAMHSA Ex. 12.

These costs resulted from KBHC's decision to restructure its operation, effective April 1, 2004, by terminating all employees except its executive director and moving to office space belonging to NMHA. KBHC Br. at 7. Thereafter, KBHC contracted with "NMHA personnel to carry out the day-to-day bookkeeping and administrative tasks." Id. KBHC represents that this action was intended to reduce its costs. Id.; see also KBHC Ex. A, at 10.

In its initial appeal file, KBHC submitted no agreement with NMHA, no bills/invoices from NMHA, and no records of payment to NMHA to support its assertion that it incurred $73,760 in costs to NMHA for "three months of administrative and general support services."

In its response brief, SAMHSA argues, among other things, that "KBHC failed to show how expenses reached the amount of $73,760" and that there was a "lack of documentation supporting the amount of the expenditure." SAMHSA Response Br. at 19. In its exhibits, SAMHSA includes an unsigned "Memorandum of Agreement" between KBHC and NMHA. SAMHSA Ex. 12. At the top of the agreement, the typed words "March 1, 2004 (Amended April 1, 2004)" appear along with a date stamp of "April 13, 2004." The agreement states that, from April 1, 2004 through September 30, 2004, KBHC will pay NMHA $15,000 a month for "administrative support," "financial compilation and reporting," "meetings and travel support," and "office space." Additionally, the agreement provides that KBHC will reimburse NMHA for KBHC's actual copying costs, long distance charges, and postage and delivery charges.

With its Reply Brief, KBHC submits a cover letter from NMHA dated March 2005 with eight attached invoices for bookkeeping services and an undated document titled "National Mental Health Association KBHC Contract for Administrative Support Addendum A Budget Justification" (addendum). KBHC Ex. P. KBHC cites these invoices as proof that SAMHSA was aware that KBHC "continued to occupy space at and receive services provided by NMHA throughout the relevant period." KBHC Reply Br. at 5. KBHC never explains the role of the addendum or how it related to its agreement with NMHA.

Both the recipient and subrecipient of a federal award bear the burden of adequately documenting the allowability of costs charged to the award. 45 C.F.R. §§ 74.21(b)(7), 74.27(a); Delta Foundation, Inc., DAB No. 1710, at 29 (1999), aff'd 303 F.3d 551, 568-570 (5th Cir. 2002); Action for Youth Christian Council, Inc., DAB No. 1651, at 8 (1998) and cases cited therein; Mexican American Unity Council, DAB No. 1341, at 13 (1992), aff'd United States v. Mexican American Unity Council, No. 5A-95-CA0320 (W.D. Tex. June 25, 1996).

For the following reasons, we agree with SAMHSA that KBHC failed to document the costs claimed here. First, KBHC does not point to any evidence to support its assertion that it owes or paid $73,760 to NMHA, such as invoices from NMHA totaling this amount or any record of payments to NMHA. Moreover, KBHC characterizes the unsigned copy of the agreement with NMHA submitted by SAMHSA as a "draft agreement" but submitted no copy of the final agreement.[4] KBHC Reply Br. at 4, citing SAMHSA Ex. 12.

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[4] KBHC represents --

(continued...)

Second, KBHC's assertion that $73,760 is owed for three months of services and space is inconsistent with both the draft agreement and the addendum.

- The draft agreement states that KBHC would pay NMHA a monthly fee of $15,000 plus charges for actual long distance calls, copying and postage. SAMHSA Ex. 12. We cannot reasonably infer that KBHC incurred $28,760 ($73,760 minus three months at $15,000) for copying, telephone, and postage over three months. This is particularly true since KBHC charged the grant separately for conference calls and KBHC did not identify any grant-funded activity that would result in extraordinary copying or mailing costs.[5]

- The addendum appears to include KBHC's copying, telephone, and postage in the $15,000 monthly charge and estimates those costs to be $1,395 per month. KBHC Ex. P, at 10.

Third, the inconsistencies between the NMHA bookkeeping invoices, KBHC's assertions, and KBHC's draft agreement with NMHA underscore the inadequacy of KBHC's evidence in support of this claim.[6] KBHC Exhibit P contains eight NMHA invoices for

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[4](...continued)
While the draft agreement attached as Exhibit 12 to SAMHSA's brief indicates an amendment effective as of April 1, 2004, the original agreement was executed prior to March 24, 2004 and had an effective date of March 1, 2004. No amendment was ever entered into by the parties.

KBHC Reply Br. at 4.

[5] AAS had been specifically instructed by SAMHSA in April 2004 that KBHC should stop all work on the publication "Suicide Prevention: The National Journal." KBHC Ex. H, at 2. SAMHSA concluded that its production "exceeds the scope of approved activities and is not essential to the operation of the hotline network." SAMHSA Ex. 6, at 1.

[6] In addition to being inconsistent with KBHC's assertions, the invoices have other evidentiary shortcomings. For example, they are all dated March 22, 2005 and are, therefore, not contemporaneous with KBHC's incurring these costs. See North Dakota Children's Services Coordinating Committee, DAB No. 1399, at 8 (1993) (Board generally reluctant to find non-contemporaneous documentation meets applicable record keeping

(continued...)

bookkeeping services for the months May 2004 through December 2004.[7] The invoices total $53,126.05, not $73,760. The charge method set out on the invoices is not consistent with the draft agreement at SAMHSA Exhibit 12 or the addendum on the last page of KBHC Exhibit P, both of which call for a fixed monthly charge. The draft agreement calls for a monthly charge of $15,000 for all support services and space. The addendum calls for a monthly charge of $15,000 but identifies the bookkeeping component of the $15,000 as $8,000. However, the invoices billed bookkeeping costs at $45 per hour, and the monthly charges on the invoices for five of the eight months are either more or less than $8,000.

Finally, for the following reasons, the record does not support an award of a lesser amount to KBHC, such as three months of the $15,000 monthly payment.

- The record does not contain the actual agreement so we are uninformed as to its actual terms.

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[6](...continued)
requirements, holding that such documentation must be closely scrutinized, citing Second Street Youth Center Foundation, Inc., DAB No. 1270, at 5 (1991)). Additionally, the invoices all contain a typed section stating "Approved for billing" with a signature line for "Catherine M. Stewart, NMHA CFO," but they are unsigned.

KBHC should have been able to produce contemporaneous documentation for these charges. 45 C.F.R. § 74.21(b). This is particularly true here because SAMHSA put this grant on high risk status on March 24, 2004. SAMHSA Ex. 4. As a condition of that status, SAMHSA required that "[a]ll requests to draw down funds awarded under this grant must be submitted to [SAMHSA] for prior approval before funds can be released." SAMHSA Ex. 4, at 2. If KBHC had been complying with this special condition on a timely basis, contemporaneous documentation of the costs comprising the $73,760 allegedly owing to NMHA should have been readily available for presentation to the Board.

[7] KBHC does not rely on the NMHA invoices to prove that it was never reimbursed and/or continues to owe NMHC $73,760 for three months of services/space costs. Rather, KBHC states only that the invoices show that "SAMHSA is fully aware that KBHC continued to occupy space and receive services provided by NMHA throughout the relevant period, and that NMHA continued to bill pursuant to the agreement. See KBHC Exh. P." KBHC Reply Br. at 4-5.

- The record supports a reasonable inference that SAMHSA previously reimbursed KBHC for some costs that were included in the $15,000 monthly payment set forth in the draft agreement. The combination of the fact that KBHC does not rely on the NMHA bookkeeping services invoices (KBHC Exhibit P) and the statement in a September 2004 SAMHSA letter that "the bookkeeper requested for KBHC is approved" (SAMHSA Exhibit 23) raise the question of whether SAMHSA previously approved and reimbursed AAS for some bookkeeping costs reflected in the NMHA invoices.[8] Alternatively, if SAMHSA was approving some other bookkeeping arrangement, then we question whether it would reasonable to also pay NMHA for bookkeeping costs under the agreement during this time period. See OMB Circular A-122, Att. A, ¶¶ A.2.a; A.3.

- Even if KBHC had proved that it incurred the unreimbursed amounts under the NMHA agreement, it has failed to prove how those amounts should be allocated between its work that was funded by this grant and its other work that was not funded by the grant. See KBHC Ex. F, at 4 (AAS correspondence stating that in 2004 KBHC would be funded at "80% level of effort for year 3 of the grant.") To be allowable under a grant, cost must be allocable to it. OMB Circular A-122, Att. A, ¶ A.2.a.

Therefore, we conclude that KBHC failed to adequately document that it incurred $73,760 or any other amount for "administrative and general support services" that have not been reimbursed by SAMHSA and that are properly allocated to this grant.

SAMHSA also asserted that KBHC was required to obtain prior approval of its agreement with NMHA. SAMHSA Response Br. at 16. KBHC disagrees and argues additionally that SAMHSA retroactively approved the agreement, and that, if SAMHSA did not retroactively

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[8] We note that KBHC states in its brief that "SAMHSA refused to cover any costs related to the KBHC/NMHA contract." KBHC Br. at 6. However, this statement is not consistent with the fact that KBHC is claiming only three months of costs for support services and space provided by NMHA while also representing that it received such benefits from NMHA from April through December. KBHC Reply Br. at 5, citing KBHC Ex. P. Further, KBHC does not deny SAMHSA's assertion that "SAMHSA already provided AAS with approximately $14,000 for services performed by NMHA for KBHC during April 2004." KBHC Ex. A, at 11.

approve the agreement, its refusal to do so was arbitrary and capricious. KBHC Br. at 8; KBHC Reply Br. at 4-6. We conclude that under 45 C.F.R. §§ 74.25(b)(1), (2), and (7), KBHC was required to obtain SAMHSA's prior approval for its arrangement with NMHA. The NMHA agreement was a central component of the KBHC's plan to completely restructure its capacity to implement the grant. The plan involved KBHC's terminating all staff (except for its Executive Director) -- including staff that it had represented in the grant application as necessary for grant implementation. KBHC Ex. C, at 26-27. In light of KBHC's failure to document these costs before the Board, however, it is not necessary for us to address whether (as KBHC asserts) SAMHSA retroactively approved the NMHA agreement, or whether (as SAMHSA asserts) SAMHSA reasonably denied retroactive approval of these expenses.

2. Forwarded Telephone and Fax Line

KBHC claims $982 for --

> expense reimbursement for payment to Verizon in order to forward the existing phone and fax line to the [NMHA office] and ensure local crisis centers could contact the new office location. KBHC felt that given the nature of the crisis hotline, it was important to provide the crisis centers with this service in case they did not receive notice of the move. The amount requested for reimbursement represents 6 months of service from Verizon.

KBHC Ex. A, at 7.

In its brief, SAMHSA disputes this claim on the ground, among others, that "KBHC never provided an itemized, chronological breakdown of the expenses that would have allowed SAMHSA to review which portion of this amount, if any, was appropriately incurred prior to the March 24, 2004 notice." SAMHSA Br. at 20.

We uphold SAMHSA's disallowance of these costs because KBHC failed to adequately document the costs before the Board. KBHC cites no exhibit containing bills from Verizon or other documentation of payment, nor do we see any documentation. Further, KBHC has failed to show why it was reasonable to pay such costs for six months after relocating.

3. Hotel expenses associated with a conference

SAMHSA denied KBHC's claim for $53,625 in hotel expenses associated with an April 2003 Crisis Center Conference in Santa

Fe, New Mexico. KBHC Ex. A, at 11. In claiming these expenses, KBHC stated to SAMHSA that --

> [the conference] was held in collaboration and partnership with the Grants Project Officer and AAS to recruit new crisis centers into the network and educate existing crisis centers. The hotel was contracted to hold this conference, however the bill was only partially paid by the grant. To date, this amount remains due to the El Dorado Hotel.

KBHC Ex. A, at 6.

In the letter disallowing these costs, SAMHSA stated that its determination was based on "written correspondence dated August 5, 2005 [wherein] AAS' executive director [the Project Director] indicated that KBHC's El Dorado Hotel expenses in question related to a 2003 Crisis Center Conference that was not grant related." Id.

KBHC argues on appeal that the conference was grant related, pointing to promotional materials that stated the conference was "geared to crisis center workers . . . . in conjunction with the 36th AAS Conference." KBHC Br. at 9, citing Ex. J, at 3. KBHC argues that "[t]his activity clearly falls within the grant purpose of dissemination of information and training of crisis center workers." KBHC Br. at 9.

The events leading up to this dispute with AAS were described in a July 2004 memo by the Project Director, the contents of which KBHC does not dispute. See KBHC Ex. I, at 13-18. The memo stated as follows:

- In May 2002, Mr. Butler of KBHC told AAS that KBHC proposed to sponsor a "shadow conference" for crisis centers in New Mexico in April 2003 to coincide with AAS's annual conference. KBHC Ex. I, at 13. AAS objected that further discussions about this proposal were needed. Id.

- In July 2002, Mr. Butler signed a contract on behalf of KBHC with the El Dorado Hotel in Santa Fe to hold a conference there in April 2003. Id.

- In November 2002, after a series of discussions, AAS, KBHC, and Contact USA (CUSA) entered into a Memorandum of Understanding (MOU) for planning, funding and producing a crisis center conference in conjunction with the AAS annual conference. Id. at 14; SAMHSA Ex. 16 (MOU). In the MOU, KBHC agreed to contribute $50,000, which it represented it

was raising from outside donors, to support the conference. Id. at 14. On the basis of this commitment, AAS and KBHC agreed that KBHC would also contribute an additional $41,000 that would come from the SAMHSA grant. Id.; SAMHSA Ex. 16, at 2.[9] AAS explained that the $41,000 was from "KBHC's grant-marketing budget . . . [for] support monies in order to lower registration fees for the conference" to attract more crisis centers to the conference. KBHC Ex. I, at 13-14. Additionally, in the MOU, KBHC agreed to independently fulfill all its contractual agreements with the El Dorado Hotel (and AAS agreed to independently fulfill all its contractual agreements with two different hotels.) Id.; SAMHSA Ex. 16, at 2. The MOU set out the conference budget and the parties' other responsibilities for production and funding of the conference.

- The conference occurred in April 2003, although KBHC never contributed the $50,000 it promised from non-grant funds.[10] KBHC Ex. I at 4, 17-18.

- In December 2003, AAS received "an invoice from the Eldorado Hotel with a cover letter stating that KBHC had informed the hotel that AAS was responsible for payment. The invoice was for $56,625.14." Id. AAS informed the El Dorado that it was not responsible for the bill.

- The El Dorado bill was reviewed by AAS. AAS sent KBHC $1,831.51 for "Eldorado Expenses Covered by the MOU" and $1,000 for the "KBHC Eldorado Deposit Reimbursement." Id. (Per the MOU, KBHC was also paid $3,367.43 as one-third of the profits realized from the conference even though KBHC had failed to contribute the $50,000 it was obligated to contribute under the MOU. Id.)

We uphold this portion of the disallowance for the following reasons. KBHC acknowledges that, in concluding that the expenses were not grant-related, SAMHSA relied on AAS's description of the course of dealing and resulting MOU among the conference

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[9] The MOU provides, "KBHC will contribute $41,000 in SAMHSA grant funds and an additional $50,000 (to a total of $91,000) as revenue toward Conference support or reduced registration fees." SAMHSA Ex. 16, at 2.

[10] The conference registration fees and $41,000 contributed from the grant were adequate to pay for the actual costs of the conference. KBHC Ex. I, at 17-18.

organizers. See KBHC Br. at 9, citing KBHC Ex. I. The undisputed facts described therein and the MOU support AAS's and SAMHSA's conclusion that these expenses were not grant-related because they were never approved, by AAS or SAMHSA, to be paid from the grant in support of this conference. The grant's contribution of $41,000 to this conference was clearly set forth in the MOU with AAS, and KBHC agreed that the additional $50,000 was to be paid from non-grant funds. Thus, even assuming, for the sake of argument, that KBHC was able to engage in grant-related activities at the conference (by, for example, recruiting crisis centers to be members of the Hopeline Network), KBHC was not authorized to spend grant funds to actually sponsor the conference beyond those authorized by AAS to be contributed from the grant. In other words, the fact that the conference provided KBHC with an opportunity to market the Hopeline Network (as did other conferences KBHC personnel attended) is not a basis for concluding that the grant should fund this conference beyond the amount that had been previously approved.

4. Shipping costs

KBHC claims $1,121 incurred for shipping a trade show display booth to the conference of the Employee Assistance Society of North America in Ottawa, Canada. KBHC Ex. A, at 7. SAMHSA disallowed this cost because the conference occurred May 13-15, 2004, which was after SAMHSA's April 23, 2004 notice to AAS that, as a high risk grantee, "marketing activities for the 1-800-Suicide [line] including use of . . . the exhibit booth and travel to conferences" should "cease immediately." KBHC Ex. H, at 2. KBHC argues that the shipment invoice shows that KBHC "incurred the obligation underlying the $1,121.00 expense prior to SAMHSA's imposition of the high risk designation on April 23, 2004." KBHC Br. at 9, citing KBHC Ex. K, at 5.

We uphold SAMHSA's disallowance of this cost. The order form for this shipment shows KBHC placed this order on April 13. KBHC Ex. K, at 5. While this action was prior to the express ban on travel imposed by SAMHSA on April 23, 2004, the exhibit was not shipped until May 3, 2004. Id. at 8. Thus KBHC had sufficient time after the April 23 letter to have avoided or, at a minimum, mitigated this expense by canceling the shipment order. Instead, KBHC chose to have the display booth shipped to Canada to its "Rep At The Event: Reece Butler." KBHC Ex. K, at 5.

5. Unemployment compensation paid to terminated KBHC employees

KBHC claimed $4,408.12 for "unemployment costs related to grant staff." KBHC Ex. A, at 6.

In response to KBHC's request for reimbursement, SAMHSA wrote -

> SAMHSA will consider these costs for reimbursement if invoices, bills, and/or documentation of payment (bank statements and cancelled checks) are provided to support the unemployment costs paid. Please note that KBHC chose to administer self insurance, rather than pay unemployment insurance premiums to the State and have it cover unemployment compensation payments. This practice is uncommon, but not prohibited. According to Attachment B Section 8.g.(b) of OMB Circular A-122, *Cost Principles for Non-profit Organizations*, payments made for unemployment compensation under a self-insured program are allowable in the year paid with the prior approval of the awarding agency. SAMHSA already reimbursed AAS for unemployment costs incurred by KBHC totaling $19,373 for the period April through September 2004.

KBHC Ex. A, at 12.

In a letter dated December 13, 2006, SAMHSA stated that KBHC did not provide SAMHSA with "invoices, bills, and/or documentation of payment" and, as a result, SAMHSA denied these costs. KBHC Ex. A, at 1.

In this proceeding, KBHC submitted bills from the Virginia Employment Commission and the Connecticut Department of Labor for unemployment compensation paid to individuals who SAMHSA does not dispute were previously employed by KBHC.[11] KBHC Ex. L. KBHC cites OMB Circular A-122, Att. B, ¶ 8.g.(3)(b) as the basis for these charges to the grant. KBHC Reply Br. at 8. That section provides --

> Where an organization follows a consistent policy of expensing **actual payments** to, or on behalf of, employees or former employees for unemployment compensation or workers' compensation, **such payments are allowable in the year of payment** with the prior approval of the awarding agency, **provided they are allocated to all activities of the organization.**

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[11] KBHC states that "SAMHSA had received the invoices on numerous occasions" and that KBHC "believes it submitted it again in response to SAMHSA's September 22 letter." KBHC Br. at 10.

OMB Circular A-122, Att. B, ¶ 8.g.(3)(b) (emphasis added).

We uphold SAMHSA's disallowance of these costs because KBHC failed to demonstrate that these expenses satisfy the requirements of OMB Circular A-122. Attachment B, paragraph 8.g.(3)(b) of the Circular provides that "actual payments . . . on behalf of . . . former employees for unemployment compensation" are "allowable in the year of payment . . . provided they are allocated to all activities of the organization."[12] While KBHC Exhibit L contains bills from the Virginia Employment Commission and the Connecticut Department of Labor, there is no indication in the Virginia documents that the amounts billed were paid by KBHC, much less what year they were paid. KBHC Ex. L, at 3-4. There is some indication of partial payment of the Connecticut bills, but we cannot tell when the payment was made or whether the payment was for amounts SAMHSA had previously reimbursed KBHC. Id. at 6-12. Further, KBHC fails to show that the amounts billed by Virginia and Connecticut were "allocated to all activities of the organization" as required by OMB Circular A-122, Att. B, ¶ 8.g.(3)(b), and Att. A, ¶ A.4.

6. Telephone expenses for conference calls

KBHC claimed $2,340 for "AccessLine" costs for "weekly conference calls with the technology team to discuss current activity, implementation goals and barriers, and next steps." KBHC Ex. A, at 8. SAMHSA denied this claim on the ground that KBHC "never provided purposes or minutes for the conference calls to

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[12] We do not discuss the requirement of prior approval by the awarding agency imposed by this section. KBHC argues that SAMHSA's letter of September 29, 2004 (SAMHSA Ex. 22) stating "Request to reimburse unemployment costs for terminated KBHC employees is approved" constituted sufficient approval. KBHC Reply Br. at 8, citing SAMHSA Ex. 23, at 1.

substantiate that they related to the grant."[13] KBHC Ex. A, at 13.

We uphold SAMHSA's disallowance of these costs because KBHC has failed to provide documentation adequate to show that all (or part) of these expenses were incurred for grant-funded work. In its brief, KBHC relies on KBHC Exhibit M, stating that "as is evident from a sampling of the minutes prepared for these conference calls over the course of the grant, such conference calls were, in fact, related to funded purposes." KBHC Br. at 10.[14] However, KBHC Exhibit M does not appear to be a "sampling of minutes prepared for these conference calls." Rather, Exhibit M contains two sets of charts of "open issues" and "closed issues" with columns for "open," "close," "issue," "originator," "assigned," and "current status/resolution." One set is dated January 20, 2004 (pages 1-11), and one set is dated February 2004 (12-16). KBHC filed no statement from a participant in these calls explaining the link between the charts and the calls and how the charts establish that all (or even some part) of the charges for these calls were for work funded by the grant.

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[13] As KBHC points out (KHBC Br. at 10), SAMHSA relied on AAS's explanation for why it had not paid these costs. AAS stated that -

> these bills allegedly were for monthly conference calls. This was never denied; rather simply returned for clarification as to who was on the call and what was the purpose of the call, e.g., minutes of the conference call would suffice, as SAMHSA would not allow me to pay such an invoice as submitted without such documentation. There simply is/was no way for me to know that these calls were grant-related without such verifiable back-up; and since Butler has consistently put in requests for payments for items not grant-related, he knows that this is required.

KBHC Ex. I, at 3.

[14] KBHC failed to include any bills from AccessLine, or any other documentation of the amount of the AccessLine bills, in its exhibits. SAMHSA did include a set of AccessLine bills under the name of "Henry Butler." SAMHSA Ex. 19. KBHC represented that the AccessLine bills were on a personal credit card because "payment had to be made as you go with a credit card. Therefore, since KBHC did not have a business credit card all of these calls were placed on Reese Butler's personal credit card." KBHC Ex. A, at 8.

7. Costs for independent contractor

On March 31, 2004, KBHC entered into a contract with an independent contractor, Edward Scofield, a computer programmer. KBHC Ex. N, at 1-6. KBHC represented to SAMHSA that Mr. Scofield "was hired to provide technology oversight, program development and launching and maintenance of the network system." KBHC Ex. A, at 7. The contract called for KBHC to pay Mr. Scofield $12,000 a month. KBHC Ex. N, at 1. SAMHSA approved payment of $6,000 per month and, pursuant to that approval, AAS "paid $6,000 for each and every month of his work submitted by invoice and summary of his activities since 1 April." KBHC Ex. I, at 3. KBHC claims $54,000 (an additional $6,000 per month) is owed under this contract "for work directly and solely related to the grant activities." KBHC Ex. A, at 7.

SAMHSA stated that it was disallowing the $54,000 because -

> KBHC had already been reimbursed for Scofield's time worked on the grant at the SAMHSA approved level of effort, 50 percent, for the period in question. Please note that because AAS' grant was classified as high risk by SAMHSA in April 2004 all subsequent expenditures had to be pre-approved by SAMHSA. Accordingly, SAMHSA notified both AAS and KBHC that Scofield's time on the grant was only approved at a 50 percent level of effort. In a June 4, 2004 email, KBHC's executive director indicated that Scofield had reduced his time worked to approximately 50 percent since the April 23, 2004 restrictions.

KBHC Ex. A, at 12-13; see also KBHC Ex. I, at 11, and SAMHSA Ex. 23.

KBHC argues that it was not required to obtain SAMHSA's prior approval for this contract because the contract was consummated prior to SAMHSA's April 23, 2004 letter instructing KBHC that such contracts should be pre-approved. KBHC Br. at 11. We do not reach the question of the impact of SAMHSA's April 2004 letter (or of the March 24, 2004 notice of Special Terms and Conditions) on the contract because, as noted in SAMHSA's April 2004 letter, prior approval of contracts with independent

contractors is required by 45 C.F.R. § 74.25(c)(7).[15] Prior approval is also required by the PHS Grants Policy Statement.

Section 74.25(c)(7) provides:

> (c) For nonconstruction awards, recipients shall obtain prior approvals from the HHS awarding agency for one or more of the following program or budget related reasons.
>
> * * *
>
> (7) Unless described in the application and funded in the approved award, . . . contracting out of any work under an award.

KBHC does not identify any description in the grant application or award approval of any of its work that was to be contracted out under the award, nor do we see any.[16] Thus, section 74.25(c)(7) required KBHC to obtain SAMHSA's prior approval for this contract.

In addition, the PHS Grants Policy Statement, which also governed this grant (SAMHSA Ex. 1, at 1), required prior approval of this contract. The PHS Grants Policy Statement requires prior approval of "[t]ransferring to a third party, by contracting or any other means, the actual performance of substantive programmatic work." PHS Grants Policy Statement, § 8, "Prior Approval Authorities." Scofield contracted to provide "project management and telecommunications engineering for the National Hopeline Network 1-800-Suicide Hotline Evaluation Linkage Project." KBHC Ex. N, at 1. Such work is substantive programmatic work, and the grant application stated that it would be performed by a KBHC employee. KBHC Exs. C, at 26-27; E, at 12-13.

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[15] In the April 2004 letter, SAMHSA cited the uniform administrative requirements for grants to state, local and tribal governments found at 45 C.F.R. Part 92, specifically 45 C.F.R. § 92.30(d)(4). KBHC Ex. H, at 1. The applicable uniform requirement for non-profit grantees is found at 45 C.F.R. § 74.25(c)(7).

[16] Indeed, it appears that the work Mr. Scofield was performing was to be performed by KBHC staff identified in the grant application as the Web Systems Administrator and the Web Systems Technician. KBHC Ex. E, at 13, 40.

Finally, KBHC's assertion that Mr. Scofield's "work under the grant is well documented in his payment invoices to KBHC" (KBHC Br. at 12) is not supported by the record. KBHC cites its Exhibit N, at 10-11 (task/hour statement for 5/3-5/14); at 14-15 (task/hour statement for 5/17-5/28); at 18 (task/hour statement for 6/1/-6/15); at 27 (duplicate of statement at 18); at 36-37 (duplicate of statement at 10-11), and at 43-43 (duplicate of statement at 14-15). Thus, KBHC has submitted statements for only one and one-half months of an apparent nine-month payment period. To the extent that the work was undocumented, it was clearly unallowable. OMB Circular A-122, Att. A, ¶ A.2.g. Further, some of the task statements describe work on projects that SAMHSA had told KBHC in April that it would not fund. For example, KBHC Exhibit N, at 10 lists hours for work on the Resource Information and Evaluation System (RIES), even though SAMHSA stated in its letter of April 24, 2004 that grant-funded work on the RIES was to "cease immediately on receipt of this letter." KBHC Ex. I, at 9. Payments for such work were not allocable to the grant.

ATTACHMENT G:

GOULD MS, KALAFAT J, MUNFAKH JLH, KLEINMAN M: AN EVALUATION OF CRISIS HOTLINE OUTCOMES, PART II: SUICIDAL CALLERS. SUICIDE AND LIFE THREATENING BEHAVIOR 2007;37(3): 338-352.

Suicide and Life-Threatening Behavior 37(3) June 2007

An Evaluation of Crisis Hotline Outcomes Part 2: Suicidal Callers

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Jimmie Lou HarrisMunfakh, BA, and Marjorie Kleinman, MS

In this study we evaluated the effectiveness of telephone crisis services/hotlines, examining proximal outcomes as measured by changes in callers' suicide state from the beginning to the end of their calls to eight centers in the U.S. and again within 3 weeks of their calls. Between March 2003 and July 2004, 1,085 suicide callers were assessed during their calls and 380 (35.0%) participated in the follow-up assessment. Several key findings emerged. Seriously suicidal individuals reached out to telephone crisis services. Significant decreases in suicidality were found during the course of the telephone session, with continuing decreases in hopelessness and psychological pain in the following weeks. A caller's intent to die at the end of the call was the most potent predictor of subsequent suicidality. The need to heighten outreach strategies and improve referrals is highlighted.

Crisis hotlines are one of the oldest suicide prevention resources in the United States (Litman, Farberow, Shneidman, Heilig, & Kramer, 1965; Shneidman & Farberow, 1957) and United Kingdom (Day, 1974), and are now ubiquitous sources of help worldwide. One rationale for crisis hotlines (Mishara & Daigle, 2000; Shaffer, Garland, Gould, Fisher, & Trautman, 1988) is that suicidal behavior is often associated with a crisis. The psychological autopsy research generally supports the association of stressful life events, such as interpersonal losses and legal or disciplinary problems, with suicide (Brent et al., 1993; Marttunen, Aro, & Lonnqvist, 1993; Rich, Fowler, Fogarty, & Young, 1988; Gould, Fisher, Parides, Flory, & Shaffer, 1996; Runeson, 1990). Furthermore, suicide is usually contemplated with psychological ambivalence, as evidenced by surviving suicide attempters who often report that the wish to die coexisted with wishes to be rescued and saved (Shaffer et al., 1988). This wish sometimes results in a "cry for help,"

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which can be addressed by those with special training (Litman et al., 1965). Lastly, crisis services may provide relief to an individual who is in the "final common pathway to suicide" (Shaffer et al., 1988) by providing the opportunity for immediate support at these critical times through services that are convenient, accessible, and available outside of usual office hours.

Despite strong theoretical and practical justification as a suicide prevention strategy, hotlines' empirical effectiveness has yet to be demonstrated unequivocally. One measure of the effectiveness of telephone crisis services has been the assessment of suicide rates in communities served by the centers. Studies examining the impact of crisis hotlines on mortality have largely employed ecological designs. These studies have compared the suicide rates in areas with and without a crisis program or in areas before and after the introduction of a crisis program. Several studies (Barraclough & Jennings, 1977; Bridge, Potkin, Zung, & Soldo, 1977; Jennings, Barraclough, & Moss, 1978; Lester, 1973, 1974; Riehl, Marchner, & Moller, 1988; Wiener, 1969), including a meta-analysis (Dew, Bromet, Brent, & Greenhouse, 1987), found no significant effects of hotlines on suicide rates. A significant effect of Samaritan suicide prevention programs in England was found by Bagley (1968), but the results were not replicated by other researchers using more elaborate and accurate statistical techniques (Barraclough & Jennings, 1977; Jennings et al., 1978). These broad measures of community suicide rates did not, however, consider the populations reached by crisis services. Miller, Coombs, Leeper, and Barton (1984) examined race-sex-age–specific suicide rates in U.S. counties with and without, and before and after the introduction of, a suicide prevention program. A significant reduction in the suicide rate in young White females was found, but no evidence of an impact in other population groups emerged. In their paper, the authors also reported a replication of their findings on a second set of counties for a different time span. The findings of Miller et al. are consistent with surveys of hotline users that indicate that young White females are the most frequent callers to hotline services (King, 1977; Litman et al., 1965; Slem & Cotler, 1973). More recently, Lester (1997) conducted a meta-analysis of 14 studies on the relationship of suicide prevention centers on suicide rates. While the results of individual studies did not always reach statistical significance, Lester found a significant overall preventive effect. Finally, Leenaars and Lester (2004) reported two studies on the number of suicide prevention centers in ten Canadian provinces and two territories. The first assessed the relationship between the density of centers in 1985 and age-adjusted rates for 1985–1989 and found no significant preventive impact. The second assessed the relationship between the density of centers in 1994 and age-adjusted rates for 1994–1998 and found negative correlations between presence of centers and change in the suicide rates for 8 of the 12 correlations. That is, the more centers, the lower the suicide rates. When the Yukon and Northwest territories were excluded, the correlation coefficients "approached or reached statistical significance" (p. 67). They concluded that this indicated "a preventive impact, though weak, of suicide prevention centers on suicide in Canada" (p. 67). However, caution is advised against the use of the term *impact* as the authors correctly note that the study was correlational and did not take into account changes in other social variables over the period.

It is difficult to draw conclusions about the effectiveness of crisis centers from studies of the relationship between the presence of suicide prevention/crisis centers and community suicide rates without a consideration of a complementary evaluation of proximal outcomes among crisis center users. One means to evaluate proximal outcomes is through silent monitoring of calls (Mishara & Daigle, 1997). Mishara and Daigle listened to 617 telephone calls from suicidal callers to two Canadian suicide centers. Immediate or proximal effects on the reduction of depres-

sive mood and in suicidal urgency were linked to specific intervention styles, most notably an empathetic Rogerian style, which also included directive components. King, Nurcombe, Bickman, Hides, and Reid (2003) rated 100 taped suicide calls to Kids Help Line in Australia. Significant decreases in suicidality and significant improvements in the mental state of youth were observed during the course of the call (King et al., 2003).

The present study employed the callers' own ratings of their mental state and suicidality, in response to a standardized set of inquiries by the crisis counselors, at the beginning and end of the call to assess the immediate proximal effect of the crisis intervention. Research findings have indicated that individuals' self ratings of their own suicidal states are more predictive of their subsequent suicidality than clinicians' ratings (Joiner, Rudd, & Rajab, 1999). A follow-up assessment, 2 to 4 weeks later, was also conducted in the present study to assess the duration of an effect and the telephone intervention's impact on future suicidal risk and behavior. To our knowledge this is the first evaluation of telephone crisis services to employ such a follow-up assessment, despite a follow-up being considered a critical evaluation strategy (King et al., 2003; Mishara & Daigle, 2000).

The aims of the present study are to determine (1) the extent to which callers to telephone crisis services are seriously suicidal; (2) whether significant decreases in suicidality occur during the call; (3) the extent and predictors of suicidality after the call; (4) the callers' perceptions of the utility of the intervention; and (5) the types of referrals given during the calls, and the extent to which callers follow through with them.

METHODS

A detailed description of the methods of this study has been provided in the accompanying article by Kalafat and colleagues (this issue). With the exception of the variables and sample that are unique to this article, only a brief description of the methods is given. The project was approved by the Institutional Review Boards of New York State Psychiatric Institute/Columbia University and Rutgers Graduate School of Applied and Professional Psychology. A confidentiality certificate was obtained from the Department of Health and Human Service through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Sample

Adult suicidal individuals calling eight telephone crisis services/hotlines across the United States were the targeted population for this study. Between March 2003 and July 2004 telephone crisis counselors conducted assessments with 1,085 suicidal callers (39.4% male and 60.6% female). Individuals who called a center more than once during the data collection period were only assessed during their first contact with the center. The majority (72.0%) of assessed suicide callers called the center's local crisis hotline telephone number, the remaining called 1-800-SUICIDE, a national network of crisis centers. Of the 426 calls received on the 1-800-SUICIDE line, 277 (65%) were suicide calls. There were 654 nonparticipants who were not assessed because crisis counselors, using their own clinical criteria, considered the callers' risk status to be "too high." These callers were in an acute suicidal state, and as such, efforts to moderate their suicidality and/or initiate rescue procedures took precedence over the administration of our standard risk assessment (described in the measures section below). As noted in Kalafat et al. (this issue), other callers were not assessed because call volume was too high, the caller refused/hung up, the counselor thought it not appropriate to assess, or phone problems existed. Among these non-assessed callers, we could not differentiate suicidal from nonsuicidal crisis callers. Thus, we do not have a precise estimate of the total number of suicidal callers; the lower bound of the estimate is 1,739 (1,085 + 654), yielding a 62.4% participation rate (upper bound).

Between April 2003 and August 2004

follow-up assessments were conducted with 380 of the 1,085 suicide callers who completed the baseline assessment (35.3%). Follow-up assessments were conducted between 1 and 52 days from the baseline assessment date, with the average being 13.5 days. For the 380 suicide callers who were followed, 30.3% were male and 69.7% female; their age ranged from 18–72, and the mean was 36.1 years. The ethnic distribution was 66.3% White, 15.2% African American, 10.2% Hispanic, 3.5% Native American, 3.2% Asian, and 1.6% Other. Ethnicity was not coded for six callers.

The reasons for no follow-up assessment for 705 suicidal callers were: 311 (44.1%) callers at baseline refused re-contact; 273 (38.7%) callers at baseline were not asked by the counselors if they wanted to receive a follow-up call; 63 (9.0%) callers gave consent at baseline for follow-up contact but the follow-up interviewers received passive or active refusals at follow up; and 58 (8.2%) callers gave the crisis counselors invalid contact information. Common reasons for counselors not asking for consent for the follow-up call were that the caller had to quickly terminate the call or hung up before the counselor could ask. A significantly greater proportion of suicidal callers (38.7%) compared to crisis callers (8.5%) were not asked for consent at baseline. Suicide callers who did not complete a follow-up assessment were significantly more intent on dying ($F = 15.3$, $p < .001$), more hopeless ($F = 14.2$, $p < .001$), more likely to be rescued ($\chi^2 = 19.9$, $p < .001$), and less likely to be given a referral ($\chi^2 = 24.9$, $p < .001$) at baseline compared to suicide callers who completed the follow-up. However, changes in suicide state (intent to die, hopelessness, and psychological pain) from the beginning to the end of the baseline call did not vary as a function of follow-up participation status.

Measures

Suicide Risk Status. The suicide risk assessment was shaped by Chiles and Strosahl's (1995) book on the assessment, treatment, and case management of suicidal patients, and the chapter on psychiatric and psychological factors in a report by the Institute of Medicine (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), which showed evidence supporting Shneidman's (1993) concept of psychological pain as a contributing factor to suicidal behavior. The assessment was also influenced by the empirical risk factors reviewed by Joiner, Walker, Rudd, and Jobes (1999) and the factor-analytic study of the Modified Scale for Suicidal Ideation (Joiner, Rudd, & Rajab, 1997). Practical considerations as to the feasibility of conducting a risk assessment within the context of a telephone intervention also shaped the suicide risk assessment. This was based on input from the crisis center directors on our advisory board and crisis center counselors who piloted the assessments (described in Kalafat et al., this issue).

Questions assessing callers' risk status included suicidal ideation and behavior, intent to die, hopelessness, and psychological pain. Three questions were asked about the caller's thoughts of suicide (any thoughts, persistence of thoughts, and control over thoughts); one question assessed whether the caller considered suicide the only possible option to solve problems; one question asked about current plans (plus narrative of "how," "when," and "where"); one question asked whether the caller had taken any action or preparatory behavior to kill or harm him/herself immediately prior to the call; and three questions assessed past attempts (lifetime occurrence, number of attempts, and whether treatment was required). These questions were asked at the beginning of the call. Suicidal thoughts, plans, and attempts since the call to the center were reassessed at the follow-up assessment. Three *a priori* scales—*intent to die*, *hopelessness*, and *psychological pain*—were the three major outcomes of the study, and were asked at the beginning of the call to the center and repeated at the end of the call and at the follow-up. These outcomes were chosen in collaboration with our advisory board, with particular input from the crisis center directors (see details in Kala-

fat et al., this issue). These outcomes were considered to be appropriate targets for an intervention plan and their attenuation during a crisis call was deemed to be critical. The items within the intent to die, hopelessness, and psychological pain domains were each rated on a 5-point scale and averaged to derive each scale score. Higher scores indicated more of the particular domain. *Intent to die* was assessed by two questions, "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans to kill yourself?" The correlation of the items was 0.43. *Hopelessness* was comprised of two questions; callers were asked how hopeful they felt about the future and whether they felt they could go on (correlation = 0.32). *Psychological pain* consisted of two items assessing current hurt, anguish, and misery (not physical pain) and whether callers could tolerate the way they felt if their current situation did not change (correlation = 0.47). The correlations of the scales at the beginning of the call were 0.52 (intent to die and hopelessness), 0.38 (intent to die and psychological pain), and 0.43 (hopelessness and psychological pain). (The remaining measures are also described in Kalafat et al., this issue).

Client Feedback on Call. The client feedback questions were asked at the follow-up assessment. Two open-ended questions about what was or was not helpful about the call initiated the assessment: "Thinking back to the call you placed to the crisis line, can you tell me how the call was helpful to you?" "Can you tell me what was not helpful about the call?" Twenty-one close-ended questions followed the open-ended assessment and provided ratings in three areas: helper interventions, emotion regulation, and overall effectiveness, but the responses to the close-ended questions will be the focus of a future paper.

Plan of Action and Compliance. This set of questions assessed whether callers remembered, agreed with, and followed through with plans of actions developed by the crisis counselors with the callers. These questions were asked at the follow-up assessment.

Service Utilization and Compliance. These questions included the type of referral (emergency services, mental health services, social services, and information and referral services) and the extent of follow through. Information on the type of referral was obtained from the crisis counselors at baseline and the referral follow through questions were asked of the callers at the follow-up assessment.

Procedures

Baseline assessments (Time 1) were conducted by center counselors near the beginning of calls, prior to providing intervention services to callers. The suicide risk assessment was conducted with callers if they had any thoughts about killing themselves. The suicidal crisis was either self-defined by the caller or identified by the crisis worker after an assessment of risk. Not all counselors felt comfortable initiating a suicide risk assessment without some clinical indicator, such as depression, or some veiled threat. Because we tried to minimize interference with the usual interactions between the counselors and the callers, we did not require the centers' counselors to routinely initiate the risk assessment. Upon completing the intervention, counselors then conducted another assessment at the end of the call (Time 2), which included a subset of the initial questions to determine whether the intervention reduced callers' suicidal status. Local data coordinators reviewed the centers' call records on an ongoing basis and compared them to completed assessments to assure that all eligible callers were being assessed. If assessments were not conducted with potentially eligible callers, the coordinators reviewed the call records for these callers with the crisis counselors. Immediately preceding the end of the calls, counselors used a standardized script to ask callers if the research team could contact them in 1 to 2 weeks to see if they were interested in participating in the follow-up assessment. The follow-up assessments were conducted by independent research interviewers

who had prior training and experience as telephone crisis counselors. The training, quality control procedures, and consent procedures are described in detail in the article by Kalafat and colleagues (this issue); only safety procedures, specific to suicide callers, will be described here. In the beginning of the risk assessment during the call to the center, suicide callers were asked if they had done anything, including preparatory behavior, to hurt or kill themselves before they called the crisis center. If a caller was in imminent danger, the crisis center stopped the interview and initiated their standard rescue procedures. The assessment was only continued if it was helpful to keep the caller engaged while waiting for emergency rescue services to arrive.

The follow-up assessment included criteria to be used by our interviewers to determine whether callers needed intervention at follow-up. The need for intervention was defined by a past plan or actual attempt at self-injury since speaking with the center, or a serious intent to die at the time of the follow-up interview. The method for getting help to callers consisted of follow-up interviewers re-connecting callers back to the center they had initially phoned. If callers were unable to participate in a call-back to the center immediately after completing their interviews, follow-up interviewers obtained callers' consent for the center to contact the callers. In this last instance, the follow-up interviewer contacted the center and gave them the caller's contact information and details as to why the caller needed intervention.

Analytic Strategy

The primary sampling unit of the study was crisis center, and the secondary sampling unit was caller within center. Thus, we examined the extent of within-center clustering in order to determine whether this clustering variable warranted inclusion in the analyses. The sample clusters (center) had little impact on outcomes (intent to die, psychological pain, and hopelessness) as indicated by the intraclass correlation coefficients, which were all close to zero (ranging from .004 to .05). Therefore, the use of mixed-effects linear models to account for the clustering variable of center was unnecessary. Center was included as a covariate in the analyses.

A repeated measures design was employed to examine changes over time, always employing center as the between subjects factor. The measures were assessed at three points: near the beginning of the call (Time 1), at the end of the call (Time 2), and at follow-up (Time 3). The repeated measures for the suicide callers were intent to die, psychological pain, and hopelessness. These repeated measures were also examined as a function of the suicide risk elements (i.e., whether the caller had a suicide plan, had made a preparatory or actual action to harm/kill self prior to the call, or had an attempt history).

A series of logistic regression analyses were conducted to determine the baseline predictors of any suicidality (thoughts, plans, or attempts) following the crisis call. The independent variables included in separate models were intent to die, psychological pain, and hopelessness (each at the beginning and end of the baseline call), persistence of suicide thoughts, control over thoughts, considering suicide as the only solution to problems, plans to kill self, actions or preparatory behavior before the call, and a history of an attempt. Age and gender were included in all models. All significant predictors in the initial models were entered simultaneously as independent variables in a final multivariate analysis.

Those callers followed up were compared to those who were not followed up on baseline measures at the beginning of the call (as previously described) by means of univariate analyses of variance. Interactions between follow-up status and changes from Time 1 to Time 2 were examined using two-way analyses of variance.

The statistical analyses were con-

ducted with SPSS statistical software (version 12.0). Given the number of comparisons, results were considered significant at $\alpha < .001$, but results at $\alpha < .01$ are presented in the tables.

RESULTS

Presenting Problems

Suicide callers contacted the centers with a variety of problems ranging from abuse/violence (10.0%), physical health problems (16.1%), work problems (12.8%), addictions (17.9%), base needs (25.9%), mental health problems (54.7%), and interpersonal problems (58.4%), along with their suicidal crises. Gender differences were significantly related to only one type of problem: males (24.8%) had significantly more addiction problems than females (13.5%) ($\chi^2 = 21.4$, $p < .001$).

Risk Profile

Of all the suicide callers who completed the baseline assessment (1,085 callers), over half (585 callers) had a suicide plan when they called the crisis center and 8.1% (88 callers) had taken some action to harm or kill themselves immediately before calling the center. More than half (57.5%, 624 callers) had made prior suicide attempts, of which 53.2% (332 callers) had made multiple attempts and 44.1% (275 callers) had made single attempts. There were 17 callers (2.7% of those who had prior attempts) for whom the number of prior suicide attempts was not coded. Only 22.2% of the suicidal callers had no current plans, actions, or a history of suicidal behavior; 5.7% had all three suicide risks. Of those with current suicide plans, 366 (62.6%) had a history of past attempts. Of those who had taken some action to harm/kill themselves immediately before their call, 63 (71.6%) had a history of past attempts. The suicide risk profile of males and females was similar with the exception of a significantly higher rate of previous suicide attempts among the females (64.8% versus 49.3%) ($\chi^2 = 24.5$, $p < .001$). There was no significant difference in the risk profile of callers to the centers' regular line and to 1-800-SUICIDE.

Rescues

Counselors reported initiating rescue procedures with 136 (12.6%) of the callers who participated in the baseline assessment. Rescue procedures were significantly more likely to be initiated for the callers who had engaged in preparatory behavior or had done something to hurt/kill themselves (37.9%) than for callers who had not taken these actions (10.8%) ($\chi^2 = 49.2$, $p < .001$). Of the suicidal callers who had taken some action to hurt/kill themselves and had not initiated rescue ($n = 54$), eight had been unable to have a rescue initiated because the center was unable to identify the caller's telephone number or the caller refused or hung up prematurely. Rescues were initiated significantly more often for callers who had a current plan to hurt/kill themselves (19.2%) than for those without a plan (4.9%) ($\chi^2 = 45.3$, $p < .001$). Rescues were also initiated more often for callers who had a history of previous suicide attempts (15.2%) than for those with no such history (8.5%) ($\chi^2 = 10.0$, $p < .01$).

Referrals

Out of the 1,085 callers who participated in the baseline assessment, 506 (46.6%) were given a new referral, of which 284 (56.1%) were to mental health resources. An additional 116 (10.7%) callers were referred back to their current therapist or services. Of the 380 callers who participated in the follow-up, 221 (58.2%) were given a new referral at baseline, of which 151 (68.3%) were to mental health resources. An additional 52 (13.7%) callers were referred back to their current therapist or services. The overall referral rate for those who participated in the baseline was 57.3% and the rate of referral for those who participated in the follow-up was 71.8%.

Overall, the rate of referrals was some-

what *lower* for callers with more serious suicide risk profiles compared to other callers. Callers who had current plans to hurt/kill themselves received *fewer* referrals (44.2%) than callers who had no current plans (53.0%) ($\chi^2 = 7.4$, $p < .01$). Callers who had taken action to hurt/kill themselves also received fewer referrals (34.5%) than callers who had not taken any action (49.3%) ($\chi^2 = 6.5$, $p = .01$). Callers who had at least one previous suicide attempt were given the same rate of referrals (46.7%) as callers who did not have at least one previous attempt (51.2%) ($\chi^2 = 1.8$, $p > .05$). This referral pattern may reflect the significantly greater propensity of counselors to initiate rescues among callers with higher risk profiles, thus precluding any other follow-up recommendations.

Immediate Outcomes

For the 1,085 callers who completed the baseline assessment, there was a significant reduction in suicide status from the beginning of the call (Time 1), to the end of the call (Time 2) on intent to die ($F = 130.8$, $p < .001$), hopelessness ($F = 112.8$, $p < .001$), and psychological pain ($F = 181.4$, $p < .001$) (Table 1). The extent to which the immediate outcomes were modified by the suicide risk profile factors (plans, actions, and prior attempts) was examined (Table 2). Despite the considerable overlap among the risk factors, as previously noted, each was examined separately as a potential modifier. This analytic strategy allowed the clinical import of each factor to be highlighted. While callers who had a suicide plan, who had taken actions to hurt/kill themselves, or who had a history of suicide attempts had higher scores on psychological pain and were significantly more hopeless and intent on dying, there were no significant interactions between the suicide risk profile factors and time. In other words, changes from Time 1 to Time 2 were not modified by the suicide risk profile.

Intermediate Outcomes

There were significant reductions in callers' psychological pain ($F = 13.1$, $p < .001$) and hopelessness ($F = 17.0$, $p < .001$) from the end of the call (Time 2) to follow-up (Time 3) among the 380 suicide callers who completed a follow-up assessment (Table 3). However, there was no significant reduction in callers' intent to die during this period ($F = 0.19$, $p > 05$). At follow-up, 43.2% (164/380) of callers reported any suicidality (ideation, plan, or attempt) since their call to the center. Of these, 17.1% (28/164; 7.4% of total sample) had made a suicide plan, and 6.7% (11/164; 2.9% of total sample) had made a suicide attempt. Of those who made a suicide attempt after their call to the center, 63.6% (7/11) had made a prior attempt some time before their call. Intent to die at the end of the baseline call (OR = 1.7, 95% CI = 1.2, 2.3, $p < .001$), having made any specific plan to hurt or kill self prior to the call (OR = 1.6, 95% CI = 1.02, 2.4, $p < .04$), and persistent suicidal thoughts at baseline (OR = 1.6, 95% CI = 1.03, 2.4, $p < .04$) were statistically significant predictors of any suicidality (ide-

TABLE 1
Immediate Outcomes from Beginning (Time 1) to End (Time 2) of Call

	Time 1		Time 2		Main Effect of Time	
Outcomes	Mean	(*SD*)	Mean	(*SD*)	*F*	*p*
Intent to Die	2.81	(1.07)	2.31	(1.04)	130.84	.001
Hopelessness	3.41	(0.99)	2.87	(0.97)	112.79	.001
Psych Pain	4.09	(0.92)	3.47	(1.08)	181.37	.001

TABLE 2
Immediate Outcomes by Suicide Risk Profile

	Intent to Die						Hopelessness						Psychological Pain					
	Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk		Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk		Time 1	Time 2	Main Effect of Risk		Interaction Effect of Time by Risk	
Outcome	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*	Mean (*SD*)	Mean (*SD*)	*F*	*p*	*F*	*p*
Risk Profile																		
Plan	3.15	2.59					3.62	3.03					4.32	3.68				
(*n* = 585)	(1.04)	(1.10)	109.9	0.001	4.13	*ns*	(0.97)	(0.97)	40.26	.001	3.72	*ns*	(0.80)	(1.05)	50.05	.001	0.71	*ns*
No Plan	2.42	1.98					3.16	2.69										
(*n* = 468)	(0.96)	(0.85)					(0.96)	(0.92)										
Action	3.28	2.85					3.72	3.28					4.37	3.79				
(*n* = 88)	(1.15)	(1.30)	19.40	.001	1.14	*ns*	(1.04)	(1.10)	11.34	.001	1.40	*ns*	(0.89)	(1.09)	8.04	.01	0.70	*ns*
No Action	2.77	2.27					3.38	2.84					4.07	3.45				
(*n* = 980)	(1.05)	(1.01)					(0.98)	(0.95)					(0.92)	(1.08)				
Multiple Attempts	3.06	2.50					3.62	2.98					4.22	3.54				
(*n* = 332)	(1.03)	(1.07)	10.97	.001	1.22	*ns*	(0.98)	(1.00)	6.43	.01	3.83	*ns*	(0.83)	(1.07)	1.90	*ns*	1.48	*ns*
Single Attempts	2.76	2.28					3.28	2.82					4.08	3.45				
(*n* = 275)	(1.01)	(0.99)					(0.97)	(0.92)					(0.88)	(1.09)				
No Attempts	2.67	2.20					3.33	2.83					4.02	3.34				
(*n* = 440)	(1.09)	(1.03)					(0.98)	(0.96)					(0.98)	(1.10)				

TABLE 3
Intermediate (Follow-up) Outcomes

	Time 1		Time 2		Time 3		Main Effect of Time		T2–T3 Contrast	
	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	*F*	*p*	*F*	*p*
Intent to Die	2.80	(0.90)	2.35	(0.90)	2.25	(0.95)	7.57	.01	0.19	*ns*
Hopelessness	3.27	(0.93)	2.72	(0.87)	2.24	(1.09)	47.84	.001	17.03	.001
Psych Pain	4.07	(0.89)	3.42	(1.06)	2.85	(1.22)	52.84	.001	14.13	.001

ation, plan, or attempt) at follow-up (43.2% of the callers) (Table 4). When these three items were entered simultaneously in the logistic regression model, only intent to die at the end of the baseline call remained a significant predictor (OR = 1.7, 95% CI = 1.2, 2.3, $p < .002$).

Caller Feedback. At follow-up, 380 suicide callers provided a total of 668 positive responses and 83 negative responses to the two open-ended questions about what was or was not helpful about the call. There were six positive categories most frequently mentioned by suicide callers: listen and let talk (23.2% of responses; 40.8% of callers), warm and caring etc. (9.7%; 17.1%), options for dealing with concerns (7.5%; 13.2%), available and patient (7.3%; 12.9%), calm down (6.9%; 12.1%), and think clearly/new perspective (6.9%; 12.1%). Notably, 11.6% ($n =$

TABLE 4
Predictors of Suicidality (Thoughts, Plans, or Attempts) Following Telephone Intervention

	Model 1[a]		Model 2[b]	
Suicide Risks	Odds Ratio (CI)	*p*	Odds Ratio (CI)	*p*
Persistent thoughts†	1.6 (1.03–2.4)	.03	1.3 (0.8–2.0)	.30
Control over thoughts†	1.4 (0.9 –2.2)	.16	–	–
Suicide as only possible option†	0.8 (0.5 –1.3)	.29	–	–
Plans†	1.6 (1.02–2.4)	.04	1.4 (0.8–2.0)	.35
Actions/preparatory behavior†	1.1 (0.5 –2.8)	.80	–	–
Prior attempts†	1.4 (0.9 –2.2)	.11	–	–
Intent to die‡—beginning of call	1.0 (0.8 –1.3)	.96	0.9 (0.7–1.2)	.62
—end of call	1.7 (1.2 –2.3)	.001	1.7 (1.2–2.3)	.002
Hopelessness‡—beginning of call	1.1 (0.9 –1.5)	.41	–	–
—end of call	1.3 (0.9 –1.7)	.15	–	–
Psychological pain‡—beginning of call	1.0 (0.8 –1.4)	.87	–	–
—end of call	1.1 (0.9 –1.4)	.52	–	–

Note. Age and gender were included in all models.
†Dichotomous item
‡5-point scale
[a]Each suicide risk variable was entered into separate logistic models, with exception of intent to die, psychological pain, and hopelessness for which the same measure at the beginning and end of call were entered simultaneously.
[b]Suicide risk variables that were statistically significant in model 1 were entered simultaneously in model 2. Intent to die (beginning of call) was entered into model 2 despite not being statistically significant in model 1 in order to account for it when assessing intent to die (end of call).

44) of suicide callers said that the call prevented them from killing or harming themselves.

The most frequent negative feedback concerned problems with the referral (10.8% of responses; 23.7% of callers). Other concerns were raised about unhelpful interventions; such as counselors being condescending, not concerned, or abrupt (16.9% of responses; 3.7% of callers); counselors providing unhelpful solutions/suggestions (12.1%; 2.6%); and counselors not identifying the problem (8.4%; 1.8%). Six respondents stated that the call was too short (7.2%; 1.6%) and six stated that the helper asked too many questions (7.2%; 1.6%).

Action Plan Compliance. Of the 380 suicide callers who participated in the follow-up, counselors developed plans of action with 278 (73.2%) callers. Examples of action plans included having a friend come over to stay with caller; and calling friends and family members. At follow up, 60 (21.6%) of the 278 callers did not recall the plan. Of those recalling the plan, 102 (46.8%) callers completed "all" of the plan, 34 (15.6%) callers completed "most," 28 (12.8%) callers completed "some" of the plan, 24 (11.0%) callers said the plan was still "in process," and 26 (11.9%) callers had not carried out any of the plan. The extent of follow through was not coded for four callers (1.8%).

Follow Through with Referral. Of the 151 follow-up suicidal callers who were given a new mental health referral, 35% had kept or made an appointment with a mental health service in the period between the initial call to the center and the follow-up assessment.

Re-Contact with the Center. Of the 380 suicide callers who participated in the follow-up, 107 (28.2%) callers had another contact with the crisis center after their initial call. Of these callers, 59 (55.1%) callers had one additional contact, 19 (17.8%) callers had two contacts, 9 (8.4%) callers had three contacts, 4 (3.7%) callers had four contacts, 10 (9.3%) callers had between 5 and 30 contacts, and 6 (5.6%) callers did not remember the number of times. Fifty-two percent ($n = 56$) of the 107 callers had received a new referral or referral back to a mental health resource, yet only 15.8% (17) had either completed or set up an appointment.

DISCUSSION

Several studies have suggested that telephone crisis services do not reach individuals at high risk for suicide but instead attract lower-risk suicidal individuals who are more likely to attempt than complete suicide (Clum, Patsiokas, & Luscomb, 1979; Greaves, 1973; Lester, 1972; Maris, 1969; Sawyer, Sudak, & Hall, 1972). The higher proportion of females who call telephone crisis services is consistent with this conjecture (Miller et al., 1984; Mishara & Diagle, 2000). Although our study also found that females were more likely than males to call crisis services, the profile of the suicide callers indicated substantial levels of risk. Over half of the suicidal callers had current plans to harm themselves when they called the crisis service and nearly 10 percent had taken some action to hurt or kill themselves immediately prior to their call. Furthermore, nearly 60 percent of the suicidal callers had made previous suicide attempts, one of the strongest predictors of completed suicide (Gould, Greenberg, Velting, & Shaffer, 2003; Groholt, Ekeberg, Wickstrom, & Hadorsen, 1997; Reinherz et al., 1995). Notably, the suicide risk exhibited by our sample of suicide callers is probably underestimated, given the substantial proportion of callers who were not assessed as part of our research protocol at baseline ($n = 654$) because they were deemed at too high a risk of suicide by the telephone counselors. Thus, our study empirically supports an earlier impression that seriously suicidal individuals are reaching out to telephone crisis services (Dew et al., 1987).

The clinical effectiveness of the crisis intervention is consistent with the significant decreases in suicidality, specifically, intent to die, hopelessness and psychological pain, found

during the course of the telephone session, similar to a recent evaluation of telephone counseling services (King et al., 2003). The immediate suicidality outcomes were not modified by the suicide risk status of the callers. This suggests that the reductions in suicidality were not simply a function of "regression to the mean," which would have been more consistent with greater decreases among higher risk individuals. In light of these positive proximal outcomes, the relatively weak, albeit positive, preventive impact of suicide prevention centers on community suicide rates (Leenaars & Lester, 2004; Lester, 1997) suggests that greater efforts are needed to attract a greater proportion of suicidal individuals in the community.

In the weeks following the crisis intervention, callers' hopelessness and psychological pain continued to lessen but the intensity of their intent to die did not continue to diminish. Moreover, a substantial proportion (43.2%) of the callers continued to express suicidal ideation a few weeks after the initial call and nearly 3 percent had made a suicide attempt after their call. The callers' intent to die score at the end of the crisis intervention was the only significant independent predictor of suicidality following the call; although having made any specific plan to hurt or kill self prior to the call and persistent suicidal thoughts at baseline were also significant, albeit not independent, predictors of any suicidality (ideation, plan, or attempt). Our findings suggest that outreach strategies, such as follow-up calls, may need to be heightened, particularly for suicidal callers with a high level of intent to die and for callers with a history of suicide attempts, who were significantly overrepresented among those who reattempted shortly after their call to the center. Moreover, outreach efforts during the course of the call may also need to be expanded in light of our findings that a rescue procedure was initiated for only 40 percent of suicidal callers who had engaged in either preparatory behavior or an actual action to hurt or kill themselves immediately prior to calling the center.

A sizable minority, nearly 30 percent, of suicidal callers had another contact with the crisis center after their initial call. This is consistent with reported rates of repeated use of telephone crisis services (Apsler & Hoople, 1976; Mishara & Daigle, 2000; Murphy, Wetzel, Swallow, & McClure, 1969; Speer, 1971; Wold, 1973). This finding is difficult to interpret; it may indicate that the caller found the initial intervention to be useful or may merely indicate that the callers are inappropriately relying on the crisis hotline rather than getting the mental health services they need. The latter is suggested by our finding that only 16 percent of the repeat callers followed through with a mental health referral after their initial call to the centers. The need to improve referrals to mental health services by telephone crisis services is also highlighted by several findings in the present study: over half of suicidal callers presented with mental health problems at the time of the call; only about a third of the suicidal callers were given a new referral to a mental health resource or a referral back to such a service; only a third of suicide callers had followed through with the referral; and, the most frequent negative feedback by suicidal callers was about problems with referrals. While callers' follow through with referrals is a function of many factors, including caller motivation (Stein & Lambert, 1984), it appears that steps need to be taken by crisis centers and counselors to address the factors under their control; for example, increasing their knowledge of community resources, matching caller needs with appropriate services, and fostering connectedness to support services (De Leo, Buono, & Dwyer, 2002).

Limitations

The study has important limitations, as described in Kalafat et al. (this issue), which also apply to the current article. A particularly important limitation is that the study was uncontrolled, and the lack of a control condition makes it difficult to definitively attribute the reduction in suicidality to the cri-

sis intervention. However, ethical concerns about compromising the clinical services provided to callers in crisis precluded the inclusion of a control condition. Another limitation specific to this article was the low participation rate at follow-up, reflecting the difficulty of implementing outreach procedures with suicidal callers. One major obstacle was the crisis counselor's reluctance to ask for the caller's consent for re-contact. This is an area that needs to be addressed in the training of crisis counselors. The substantial differences observed between the suicidal callers who were followed and those who were lost to follow-up are problematic. Those who participated in the follow-up were significantly less suicidal than the nonparticipants; however, changes in suicide state from the beginning to the end of the call did not vary as a function of follow-up participation status; thus, we are reassured that the findings generally apply to most callers in a suicidal crisis. The results may indeed underestimate the impact of the intervention on suicidality because rescue procedures were initiated significantly more often for the suicidal callers who were not followed and were most likely initiated for a substantial proportion of the high risk individuals who were not assessed at baseline.

Conclusions

Our study provides empirical evidence that seriously suicidal individuals are reaching out to telephone crisis services. The clinical effectiveness of the crisis intervention is consistent with the significant decreases in suicidality found during the course of the telephone session, and the continuing decrease in callers' hopelessness and psychological pain in the weeks following the crisis intervention. Without a control group, however, these effects cannot be definitively attributed to the crisis intervention. Our findings also suggest that follow-up outreach strategies may need to be heightened, particularly for suicidal callers with a history of suicide attempts, who were significantly overrepresented among those who reattempted shortly after their call to the center. The need to improve referrals to mental health services by telephone crisis services is also highlighted. Lastly, any suicide risk assessment should include a re-evaluation of the caller's intent to die at the end of the call, in light of its predictiveness of subsequent suicidality.

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